STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337010	A. BUILDING _____ B. WING _____	C 09/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS ROCHESTER MONROE CO CHHA	2180 EMPIRE BOULEVARD WEBSTER, NY 14580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This statement of deficiencies is the result of the Title XVIII/XIX Article 36 complaint investigation (NY00062028) and (NY00062988) conducted by the staff of the Western Regional Office of the New York State Department of Health on 9/230/8 and 9/24/08. Six (6) clinical records and the agency complaint log were reviewed and agency staff were interviewed.	G 000	See attached.	
G 108	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. This STANDARD is not met as evidenced by: Based on clinical record review, interview with agency staff, review of the agency policy and procedures, the agency failed to ensure in three (3) of five (5) clinical records that patients who were Medicare beneficiaries, received written notification of a change in the plan of care before the change was initiated. Specifically, Section 1879 of the Social Security Act (the Act) protects beneficiaries from payment liability in certain situations unless they are notified of their potential liability in advance. The Conditions of Participation for Home Health Agencies, part 1891 of the Act requires general notification of	G 108		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mary Richards — DPS — 10/24/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 108	Continued From page 1 changes in the charges and care. The Home Care Advance Beneficiary Notice (HHABN) is to be provided to Medicare beneficiaries to meet these requirements. There is the potential for the patient to lack understanding of his/her rights and places the patients at risk for not receiving the care needed to meet their goals. Patients affected are 2, 3 and 5. Findings are: Patient 2 - This 71-year-old patient was admitted to the home care agency on 6/21/08 with diagnoses that included post operative infection status post total hip replacement, staphylococcal infection and abnormality of gait. The patient had been receiving nursing visits two (2) to three (3) times a week for wound care under Medicare. The clinical record documented that the patient was homebound at the start of care (SOC) due to "limited endurance related to the wound". At the visit on 7/31/08, the nurse documented in the clinical record that the patient's wound VAC had been discontinued by the physician and that the patient was "homebound prior to today's visit due to VAC dressing". The nurse contacted the agency regarding the patient no longer being homebound. Arrangements were made with the patient to receive a private pay visit to teach the patient her wound care procedure. On 8/4/08, a visit was made to teach the patient to perform the wound care and to discharge the patient. There was no documented evidence that the patient received the Home Care Advance Beneficiary Notice (HHABN) prior to or at the time of discharge, due to no longer meeting the	G 108	See attached.	

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G 108	Continued From page 2 homebound criteria for Medicare coverage. The agency failed to follow the policy titled, "Documentation" (revised 5/28/08). The policy stated that the HHABN is given to the Medicare beneficiary when "during an episode: a patient no longer meets the eligibility criteria for one or more services that continue to need to be a patient's care plan". Interview conducted with the Director of Patient Services (DPS) on 9/25/08 confirmed that there was no HHABN present in the patient's record. Patient 3 - This 85-year-old patient was admitted to the home care agency on 7/12/08 with diagnoses that included infection due to heart device, coronary artery disease and decubitus ulcer. The patient received services from the home care agency through Medicare Home Maintenance Organization (HMO). According to the Physical Therapy orders for the certification period of 7/12/08 to 9/9/08, the therapist was to visit the patient 1-3 times a week for five (5) weeks and the 4-8 times a month for one (1) month. The patient was seen as ordered during the first five (5) weeks. At the visit by the Physical Therapist on 8/12/08, therapy services were discontinued. The therapist did not complete the visits according to the original plan of care. There was no documented evidence that the patient had received the Home Care Advance Beneficiary Notice (HHABN) prior to or at the time of this change in the plan of care. The agency failed to follow the policy titled,	G 108	See attached.	

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G 108	Continued From page 3 "Documentation" (revised 5/28/08). The policy stated that the HHABN is given to the Medicare beneficiary when "during an episode: an unanticipated service reduction or discharge occurs". Interview conducted with the Director of Patient Services (DPS) on 9/24/08 confirmed that there was no HHABN present in the patient's record. Patient 5 - This 71-year-old patient was admitted to the home care agency on 8/6/08 with diagnoses that included aftercare for joint replacement, status post ankle replacement, abnormality of gait and long term anticoagulant use. According to the plan of care (POC) for the certification period of 8/6/08 to 10/4/08 the patient was to receive nursing visits two (2) to eight (8) times a month for two (2) months. The patient's payer source, according to the clinical record was a Medicare Home Maintenance Organization (HMO). The patient received nursing services as ordered for the first month. Nursing services were discontinued on 8/25/08. There was no documented evidence that the patient had received the Home Care Advance Beneficiary Notice (HHABN) prior to or at the time of the change in plan of care. The agency failed to follow the policy titled, "Documentation" (revised 5/28/08). The policy stated that the HHABN is given to the Medicare beneficiary when "during an episode: an unanticipated service reduction or discharge occurs".	G 108	See attached.	

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G 108	Continued From page 4 Interview conducted with the Director of Patient Services (DPS) on 9/24/08 confirmed that there was no HHABN present in the patient's record.	G 108		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and staff interviews, the agency failed to ensure in one (1) of six (6) clinical records that the staff coordinated effectively and supported the objectives outlined in the plan of care. The issues are assignment of multiple nurses to one patient and failure to consult with nutrition. Failure to coordinate services has the potential to result in the lack of provision of services or the provision of improper services, which could negatively impact the patient's health and welfare. Patient affected is 3. Findings are: Patient 3 - This [redacted] year-old patient was admitted to the home care agency on 7/12/08 with diagnoses that included infection due to heart device, coronary artery disease and decubitus ulcer. At the start of care (SOC) on 7/12/08, the nurse documented in the clinical record that the patient weighed 73.2 pounds and that this was the patients' "actual weight". On 7/14/08 the patients' weight was documented as 75 pounds. On 7/17/08, the patient weighed 70.6 pounds and the	G 143	See attached.	

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G 143	Continued From page 5 nurse instructed the caregivers to weigh the patient daily and maintain a log. On 7/23/08, the patient weighed 70 pounds according to the clinical documentation. At nursing visit on 7/25/08, the nurse documented that the patient reported that she weighed 68 pounds, and that the patient was using Boost in the evening. On 7/30/08, the nurse documented in the clinical record that the patient's "actual weight" was 65 pounds. According to the documentation, the nurse was instructed to "mix ice cream with Boost for more calories". There was no documented evidence that the physician had been consulted regarding the patient's weight loss or that a dietician had been consulted regarding methods to manage the patient's nutritional needs. There was no documented evidence that an order had been obtained for the use of any nutritional supplements. There was no documented evidence of coordination of care between nursing staff members. Eight different nurses were assigned to visit the patient out of the ten (10) visits made. There was no documented evidence that care was coordinated for nursing to assess the patient for the weight loss. Interview conducted with the Director of Patient Services on 9/24/08 acknowledged these findings and presented that the case manager should have recognized that the patient had experienced this weight loss. The agency does have a dietician for consultation.	G 143	See attached.	
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and	G 159		

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G 159	Continued From page 6 equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and interview with agency staff, the agency failed to ensure in four (4) of six (6) clinical records that the plans of care were of sufficient scope to meet the patient's needs. The issues are incomplete orders for wound VAC, failure to obtain orders for medications being utilized by the patients, lack of orders for the measurement of oxygen saturation, lack of orders defining the "as needed" reason for measuring oxygen saturation or performing an electrocardiogram (EKG) and lack of orders for use of nutritional supplements. Failure to have comprehensive plans of care has the potential for staff to act on incomplete information that may result in inappropriate care. The patients affected are 2, 3, 4 and 5. Examples are: Patient 2 - This [redacted] year-old patient was admitted to the home care agency on 6/21/08 with diagnoses that included post operative infection status post total hip replacement, staphylococcal infection and abnormality of gait. On 7/1/08, an order was received by the agency to "apply VAC dressing 2-3 times a week and prn (as needed). The order lacked VAC system pressure setting and type of dressing material to	G 159	See attached.	

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G 159	Continued From page 7 be applied to the wound. According to the "VAC Therapy Clinical Guidelines" (July 2007) that the agency utilized as a reference source, the physician order should include "therapy settings (i.e.: intermittent or continuous), pressure settings in millimeters of mercury (mmHg) and dressings to be used (i.e.: VAC GranuFoam, VAC GranuFoam silver, specific speciality dressings to be used or VAC WhiteFoam dressings) and any adjunct dressings to be used (non-adherent materials or other). Interview conducted with the Director of Patient Services on 9/24/08 confirmed these findings. Patient 3 - This [redacted]-year-old patient was admitted to the home care agency on 7/12/08 with diagnoses that included infection due to heart device, coronary artery disease and decubitus ulcer. The plan of care (POC) for the certification period of 7/12/08 to 9/9/08 directed that the patient follow a heart healthy diet. At the nursing visit on 7/25/08, the nurse documented that the patient reported she was using Boost in the evening. On 7/30/08, the nurse documented the in the clinical record that she instructed the patient to "mix ice cream with Boost for more calories". There was no documented evidence that the physician had been consulted or had ordered a nutritional supplement for the patient to use. The POC directed the nurse to measure oxygen saturation as need (PRN) and to perform electrocardiogram (EKG) PRN. There was no documented evidence of an order defined when these tasks would need to be performed.	G 159	See attached.	

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G 159	Continued From page 8 At the visit on 7/23/08, the nurse documented in the clinical record that the patient was receiving "good effect with Tylenol" for pain management. There was no evidence of an order for the patient to use Tylenol for pain. Interview conducted with the Director of Patient Services on 9/24/08 confirmed these findings. Patient 5 - This [redacted] year-old patient was admitted to the home care agency on 8/6/08 with diagnoses that included aftercare for joint replacement, status post ankle replacement, abnormality of gait and long term anticoagulant use. According to the plan of care (POC) for the certification period of 8/6/08 to 10/4/08 the patient was "independent with Fragmin injections". There was no documented evidence on the POC that Fragmin was ordered. Coumadin 5 milligrams (mg) every evening by mouth, was ordered, but there was no documented evidence of orders for monitoring the Coumadin with routine laboratory or anticoagulant precautions. Interview conducted with the Director of Patient Services presented that the patient had been on Fragmin for two days and that an outpatient laboratory was doing blood draws as arranged by the hospital prior to the patient's discharge. She confirmed that these items were not on the POC. At the visits on 8/11/08, 8/18/08 and 8/25/08, the nurse measured the patient's oxygen saturation. At the visits on 8/11/08 and 8/25/08, the nurse documented that the patient was using Tylenol. There was no evidence of an order for the nurse to perform the oxygen saturation measurement or	G 159	See attached.	

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G 159	Continued From page 9 for the patient to take Tylenol. At the physical therapy visit on 8/25/08, the therapist documented in the clinical record that the patient was taking Avelox for bronchitis. There was no documented evidence of the route, dosage or frequency the patient was to use the medication or that the therapist identified a new prescription in the patient's home. Interview conducted with the Director of Patient Services on 9/24/08 confirmed these findings.	G 159	See attached.	

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J 000	Initial Comments This statement of deficiencies is the result of the Title XVIII/XIX Article 36 complaint investigation (NY00062028) and (NY00062988) conducted by the staff of the Western Regional Office of the New York State Department of Health on 9/230/8 and 9/24/08. Six (6) clinical records and the agency complaint log were reviewed and agency staff were interviewed.	J 000	See attached.	
J 604	763.6(a) Patient Assessment and Plan of Care 763.6 Patient Assessment and Plan of Care. (a) A comprehensive interdisciplinary patient assessment shall be completed, involving, as appropriate, a representative of each service needed, the patient, the patient's family or legally designated representative and patient's authorized practitioner. Such assessment shall address, at a minimum, the medical, social, mental health and environmental needs of the patient. This Regulation is not met as evidenced by: Based on clinical record review and interview with agency staff, the agency failed to ensure in three (3) of six (6) clinical records that the patients' immunization status was assessed. Specifically a "Dear Administrator Letter" was issued by the New York State Department of Health of 12/1/06. It stated that, Assessment of the patients must include an assessment of the patients' immunization status". Failure to evaluate the patients's immunization status as part of the assessment process has the potential to result in	J 604		

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J 604	Continued From page 1 the patient to clinical staff being exposed to preventable communicable disease. The patients affected are 3, 4 and 5. The findings are: Patient 3 - This [redacted]year-old patient was admitted to home care agency on 7/12/08 with diagnoses that included infection due to heart device, coronary artery disease and decubitus ulcer. There was no documented evidence that the patient's immunization status was assessed at the start of care. Patient 4 - This [redacted]-year-old patient was admitted to the home care agency on 7/23/08 with diagnosis that included open wound of lower leg, peripheral vascular disease and coronary artery disease. There was no documented evidence that the patient's immunization status was assessed at start of care. Patient 5 - This [redacted]-year-old patient was admitted to the home care agency on 8/6/08 with diagnoses that include aftercare for joint replacement, status post ankle replacement, abnormality of gait and long term anticoagulant use. There was no documented evidence that the patient's immunization status was assessed at the start of care. Interview conducted with the Director of Patient Services on 9/24/08 presented no further information as to why this information had not been gathered on all patients as the clinical staff	J 604	See attached.	

New York State Department of Health

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J 604	Continued From page 2 has been made aware of the need to do so.	J 604	See attached.	

(X4)ID PREFIX Tag	PROVIDER'S PLAN OF CORRECTION	(X5) Responsible Party and Completion Date
	Telephone message left with Kristine Coughlin RN, 10/20/08, requesting clarification about regulation sited in G108 for the NON Medicare population. Visiting Nurse Service has interpreted the regulation to assume that it applies ONLY to Medicare Recipients. On 10/23/08, Kristine confirmed this interpretation.	
G 108	**484.10(c)(1) Right to be Informed and Participate** Patient Corrective Action Patient 2 was informed in advance of the termination of her Medicare Benefit due to her homebound status. "Patient agrees to private pay additional visit to learn/do wound care next Monday...Defers having nurse come back out today to redo wound care and have patient do the dressing change. Defers having wound care instruction performed at MD office. Prefers to pay privately for 1 additional visit." 7/31/08. However, no Home Health Advanced Beneficiary Notice (HHABN) was obtained as required. Patient was closed to Visiting Nurse Service (VNS) as of 8/4/08. Patient 3 – not applicable. VNS billed Preferred Care Gold (HMO); therefore the regulation does not apply. Patient 5 – not applicable. VNS billed Preferred Care Gold (HMO); therefore the regulation does not apply. Identification of Other Patients VNS will develop a report to identify Medicare beneficiaries who have had their benefit changed to an alternative payment source (termination of benefit). VNS will develop a report to identify Medicare beneficiaries in which a service has closed (reduction of service). VNS will develop a report to identify Medicare beneficiaries who have been discharged from the agency (termination of benefit). Reports will be utilized to identify patients who required an HHABN before making the service change and then tracking the presence of the form. Control Measures VNS will develop training for all clinical staff to re-educate on the HHABN regulation. VNS will update policy #424 to clarify – HHABNs and reeducate staff. VNS will reeducate on the change payor process and provide internal clerical support to track HHABNS. Internal clerical support will monitor previously mentioned reports for compliance. Quality Measures Previously mentioned compliance reports will be distributed weekly to designated staff for tracking and follow up as needed.	Wende Copeland, Clinical Team Manager (CTM)– 10/31/08 Mary Nicholson, Director of Clinical Operations and Quality, DPS – 12/31/08 Mary Nicholson, DPS – 12/31/08 Mary Nicholson DPS– 12/31/08

G143	**484.14(g) Coordination of Care** Patient Corrective Action Patient 3 is presently closed to the agency; however a follow up call will be made to the patient and family to check on status. Verbal order will be obtained to clarify the diet. Identification of Other Patients VNS will conduct random Utilization Review Audits to assess for documented evidence of coordination of care in the 4th quarter 2008. UR results will be shared with staff and individual follow up will occur with case managers as needed. Control Measures VNS will reeducate staff involved with patient care on the requirements of care coordination for our patients. VNS will develop a standard case management "Case Management University" curriculum that will be offered quarterly to case managers. The curriculum will include care coordination. VNS will edit the case conference tool to include documented evidence of care coordination. Clinical team managers will case conference with case managers and document at least 5 audits of patient records using the case conference tool for each case manager. VNS clinical model will be structured so as to improve care coordination. • Care coordination specialists (planners) will have a central reporting mechanism to improve communication among teams. • Increase the number of field case managers by moving internal case managers into these positions with the goal of improving continuity of care. Quality Measures VNS will conduct random Utilization Review Audits to assess for documented evidence of coordination of care in the 4th quarter 2008. UR results will be shared with staff and individual follow will occur with case managers as needed.	Julie Salo, CTM -10/31/08 Irene Mele, Senior Quality Management Nurse – 12/31/08 Julie Salo CTM, Susan Pucko, CTM – 12/31/08 Mary Kelly, Director of Education – 3/31/08 Mary Nicholson, DPS – 12/31/08 Mary Nicholson, DPS – 12/31/08 11.3.08 Mary Nicholson, DPS – 12/31/08

G 159	**484.18 (a) Plan of Care** Patient Corrective Action Plan Patient 2 is presently closed to the agency. A verbal order will sent to clarify the wound vac orders. A case conference was held with the case manager about the lack of specificity around the order. The case manager reported understanding the requirements of wound orders.	Wende Copeland, CTM – 10/31/08
	Patient 3 is presently closed to the agency. An order will be sent to the physician to clarify the diet orders, the use of nutritional supplements, the use of tylenol and to clarify the PRN parameters for the EKG and oxygen saturation rate. Case conferences will occur with the 2 nurses who documented nutritional supplements other than what was on the plan of care. Case conference will be held with the nurse who documented the use of Tylenol without an order to support the use of this analgesic.	Lainie Detomaso, Assistant Evening Manager and Julie Salo, - CTM- 10/31/08
	Patient 5 is presently close to the agency. An order will be sent to the physician to clarify the order for Fragmin, Tylenol, Avelox and oxygen saturation, which were documented, but not included on the POC. A case conference will be held with the case manager to review the requirement of a comprehensive POC and adhering to the POC orders. Case conferences will be held with staff who documented medications and treatments without supporting orders	Susan Diangelo, CTM Susan Pellegrino, CTM Susan Pucko CTM – 10/31/08
	Identification of Other Patients VNS will conduct random Utilization Review Audits to assess for documented evidence of coordination of care in the 4th quarter 2008. UR results will be shared with staff and individual follow up will occur with case managers as needed.	Irene Mele, Senior Quality Management Nurse (Senior QM)– 12/31/08
	Control Measures VNS will re educate staff on the requirement to follow the established POC.	Mary Nicholson, DPS – 12/31/08
	VNS will develop a standard case management "Case Management University" curriculum that will be offered quarterly to case managers. The curriculum will include following the established POC.	Mary Kelly, Director of Education – 3/31/08
	VNS will edit the case conference tool to include documented evidence of care coordination. Clinical team managers will case conference with case managers and document at least 5 audits of patient records using the case conference tool for each case manager.	Mary Nicholson, DPS – 12/31/08
	Quality Measures VNS will conduct random Utilization Review Audits to assess for documented	Irene Mele,

11.3.08

	evidence of coordination of care in the 4th quarter 2008. UR results will be shared with staff and individual follow up will occur with case managers as needed. VNS will conduct random audits (30) of treatment plans (485) in the 4th quarter 2008. Results will be shared with staff and individual follow up will occur as needed.	Senior QM, 10/31/08 Eileen Volkmar, Senior Quality Nurse – 12/31/08
J 604	**763.6(a) Patient Assessment and Plan of Care** Patient Corrective Action Plan Patient 3, 4 and 5 are presently closed to VNS. Case conferences will be held with the assessment staff to re instruct on the requirement to assess immunization status as part of the comprehensive assessment. Identification of Other Patients VNS will develop a report to identify active patients who were not screened for immunizations at the SOC since 12/1/06. VNS will screen these patients and follow up with the physician accordingly. Control Measures VNS will review and update the Admission Process Standard to include the requirement to screen for immunizations. VNS will update the Start of Care template report to include follow with physician if identified by the screening. VNS will develop a report to identify new admissions that were not screened at as part of the comprehensive assessment. VNS will insure that patients are screened and/or the physician notified as needed. Quality Measures VNS will develop a report to identify new admissions that were not screened at as part of the comprehensive assessment. VNS will insure that patients are screened and/or the physician notified as needed.	 Susan Diangelo, CTM, Wende Copeland CTM, Jennifer Russell, CTM – 10/31/08 Mary Nicholson DPS, 12/31/08 Mary Nicholson DPS, 12/31/08 Mary Nicholson DPS, 12/31/08 Mary Nicholson DPS, 12/31/08

11.3.08

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Rochester Field Office
Triangle Building 335 East Main Street Rochester, New York 14604-2127

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 14, 2009

Ms. Inga Cordaro
105 Lycell Street
Spencerport, NY 14559

Re: Complaint #NY00064091

Dear Ms. Cordaro:

I am writing to inform you of the results of the investigation of your recent complaint against **VNS Rochester Monroe County CHHA**.

During the investigation, we visited the agency, interviewed staff and reviewed records. Our investigation revealed that the agency has violated a portion of Federal Conditions of Participation. A statement of deficiencies was issued to the agency, and a plan of correction was received by this office.

If you have any questions, you may contact this office at (585) 423-8111. Thank you for your cooperation.

Sincerely,

Margaret M. Jordan
Home Care Director
Western Regional Office/Rochester

MMJ/tmc

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337010	A. BUILDING _____ B. WING _____	C 01/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS ROCHESTER MONROE CO CHHA	2180 EMPIRE BOULEVARD WEBSTER, NY 14580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 000	Initial Comments This statement of deficiencies is a result of the Title XVIII/XIX Article 36 extended recertification survey and complaint investigation (NY0064091) conducted by the Western Regional Office of the New York State Department of Health on 10/29/08, 10/30/08, 11/4/08, 11/5/08, 11/6/08, 11/7/08, 11/12/08, 11/13/08, 11/14/08, 11/17/08, 11/18/08, 11/19/08, 11/21/08, 11/24/08, 11/25/08, 11/28/08, 12/01/08, 12/2/08, 12/3/08, 12/4/08, 12/5/08, 12/8/08, and 12/9/08. During this survey, forty-two (42) clinical records were reviewed and twenty-five (25) home visits were conducted. Ten (10) of the patients were part of the CMS Home and Community Based Waiver Long Term Home Health Care Program.	J 000		
J 308	763.3(a)(2) Patient Care 763.3 Patient Care. (a) The governing authority shall ensure that a comprehensive array of services is available and provided as needed. .... (2) For a long term home health care program or AIDS home care program, such services shall include as a minimum: nursing services; home health aide services; medical supplies, equipment and appliances; physical therapy; occupational therapy; respiratory therapy; speech-language pathology; audiology; medical social work; nutritional services; personal care; homemaker and housekeeper services.	J 308		3/5/09

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J 308	Continued From page 1 This Regulation is not met as evidenced by: Evidence is lacking that the governing body ensures all required services and all wavered services are available for the agency's Long Term Home Health Care Program. These services enable patients to remain in their homes and avoid having to reside in a skilled nursing facility. Specifically, evidence is lacking the agency has audiology, institutional respite care, and medical equipment services available. On 11/25/08 the surveyor requested to see the agency's contracts for audiology, institutional respite care, and medical equipment. The Director of Patient Services/Director of Clinical Operations stated the agency does not have a contract in place for audiology services or medical equipment. The contract presented for institutional care was a contract between the agency's Hospice program and a nursing facility. Failure to provide all required services has the potential for unmet patient needs, and possible negative patient outcomes.	J 308		
J1301	763.12(a)(1)(i-iv) Contracts 763.12 Contracts. (a) The governing authority may enter into contracts with individuals, organizations, agencies or facilities, when necessary, to provide or obtain those services required by patients. Such contracts shall specify: (1) the contracting parties' agreements, including, but not limited to: (i) the services to be provided;	J1301		3/5/09

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J1301	Continued From page 2 (ii) the manner in which services will be supervised and evaluated; (iii) charges, reimbursement and other financial arrangements; and (iv) any provisions made for indemnification between the agency and the contract provider; This Regulation is not met as evidenced by: Based contract review and interview with agency staff, the Governing Authority failed to ensure that seven (7) of nineteen (19) contracts complied with the regulations regarding contract clause requirements. Six (6) contracts lacked an indemnification provision within the contract and one (1) contract lacked the requirement for supervision and evaluation of service. Specifically, the contracts with Medical Motor Service of Rochester and Monroe County, Brian R. LeSuchander, Seniors First Adult Day Program at Valley Manor, Unity Health Systems, Bauer and Son Moving, Inc., and Genesee Transportation, Inc. lack the indemnification provision. Rochester Medical Transport, Inc. contract lacked the supervision and evaluation of service provision. There is the potential for one of the parties involved in the contract to overlook or deny services as agreed to in the contract provisions which could cause a lapse or omission of the service to the patient. These findings were reviewed with the Vice President, Clinical Operations and Director of Patient Services/Director of Clinical Operations on 12/02/08. No additional information was offered.	J1301		

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J1304	Continued From page 3	J1304		
J1304	763.12(a)(2) Contracts 763.12 Contracts. (a) The governing authority may enter into contracts with individuals, organizations, agencies or facilities, when necessary, to provide or obtain those services required by patients. Such contracts shall specify: .... (2) that contracted personnel meet the personnel requirements as set forth in section 763.13 of this Part, which can be verified by written documented evidence and examined by the agency and the department on request; This Regulation is not met as evidenced by: Based on contract review and interview with agency staff, three (3) of nineteen (19) contracts entered into by the agency to obtain or provide patient care services lacked the personnel requirement clause within the contract. Specifically, the contract with Generations, Seniors First Adult Day Program at Valley Manor and Unity Health Systems lacked this provision. There is the potential for staff provided under the contract to lack the necessary training and health requirements and as a result may place patients at risk for negative outcomes. These findings were reviewed with Vice President, Clinical Operations and Director of Patient Services/Director of Clinical Operations on 12/2/2008. No additional information was offered.	J1304		3/5/09
J1328	763.12(a)(8)(i-iii) Contracts 763.12 Contracts.	J1328		2/5/09

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J1328	Continued From page 4 (a) The governing authority may enter into contracts with individuals, organizations, agencies or facilities, when necessary, to provide or obtain those services required by patients. Such contracts shall specify: .... (8) the following terms and conditions: "Notwithstanding any other provisions in this contract, the agency remains responsible for: (i) ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations; (ii) planning, coordinating and ensuring the quality of all services provided; and (iii) ensuring adherence to the plan of care established for patients." This Regulation is not met as evidenced by: Based on contract review and interview with agency staff, the Governing Authority failed to ensure in eight (8) of nineteen (19) contracts complied with the requirement for the "Notwithstanding any other provisions of this contract" clause. Specifically, the following contacts lacked this clause: Generations, Seniors First Adult Day Program at Valley Manor, Unity Health Systems, Medical Motor Service of Rochester and Monroe County, Brian R. LeSchander, Bauer and Son Moving, Inc., Rochester Medical Transport, Inc. and Genesee Transportation, Inc. There is the potential for one of the parties involved in the contract to overlook or deny services as agreed to in the contract provisions which could cause a lapse or omission of the	J1328		

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J1328	Continued From page 5 service to the patient. These findings were reviewed with the Vice President, Clinical Operations and Director of Patient Services/Director of Clinical Operations on 12/2/08. No additional information was provided.	J1328		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337010	A. BUILDING _____ B. WING _____	C 10/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 000	INITIAL COMMENTS This Statement of Deficiencies is a result of a complaint investigation #NY00049553 conducted by staff of the Western Regional Office of the New York State Department of Health on 10/18/07.	G 000	See attached.	
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on record review, agency policy review, and staff interviews, in one (1) out of three (3) complaints, the agency did not document the existence of a patient complaint into their agency complaint log. This has the potential to result in grievances not being resolved in an efficient manner, circumventing committee input that could recommend a change in agency policy or procedure. Review of the one complaint revealed that the patient was upset with the lack of respect from the home health aide, and had provided a written complaint to the registered nurse during a home visit on 8/3/07. The nursing supervisor was making a co-visit with the registered nurse that day and hand delivered the written complaint to the agency president's office of that agency that afternoon. Review of the Agency Complaint Log	G 107		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Richards — TITLE: Director of Corporate Compliance DPS — (X6) DATE: 11/10/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 107	Continued From page 1 on 10/18/07 revealed that the Director of Patient Services (DOPS) did not document the complaint into the agency log. Upon review of the policy entitled "Patient Grievances", the policy states a "Patient/Service Complaint Form" would be initiated by any employee receiving the complaint. The Quality and Compliance Committee reviews a summary of the "Patient Complaints Report" on a quarterly basis. The summary of the third quarter 2007 "Patient Complaints Report" did not include a report of this incident. During an interview on 10/18/07, the supervisor admitted dropping off the written complaint on 8/3/07 to the agency president's office and the DOPS agreed that the complaint was not documented into the agency's complaint log.	G 107	See attached.	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) Responsible Party and Completion Date
G107	Exercise of Rights and Respect for Prop Patient RJ Corrective Action for patient RJ DOH complaint investigation and follow up were completed and the corrective action plan was accepted, however, the patient complaint was not added to the Visiting Nurse Service (VNS) complaint log. The patient complaint was added to the log on 10/23/07. The Director of Patient Services (DPS) understands the significance of this oversight and assumes full responsibility. Complaints are reported to the VNS Quality and Compliance committee (PAC) and this complaint will be reported to this committee on 11/15/07. Corrective Action for identifying other patients The DPS will reeducate VNS management team on the complaint process. This will include: 1. Revised complaint form that was created after a Quality Department review of complaint documentation. 2. Complaint policy and requirement that complaints are logged. DPS instructed all managers to assess if complaints that are in the process of resolution have been added to the complaint log. In addition, this communication included the importance of why this regulation exists. This occurred on 11/9/07. Corrective Action for systemic change The DPS will reeducate VNS management team on the complaint process. This will include: 1. Revised complaint form that was created after a Quality Department review of complaint documentation. 2. Complaint policy and requirement that complaints are logged. DPS instructed all managers to assess if complaints that are in the process of resolution have been added to the complaint log. In addition, this communication included the importance of why this regulation exists. This occurred on 11/9/07. VNS Quality department made recommendations to President and CEO, Victoria Hines, after an internal review completed in September. These include: 1. A revised complaint form with defined instructions for follow-up and required documentation. 2. Added internal control for a member of the Administrative group to follow up with the complainant, as deemed appropriate by the DPS or Director of Clinical Services (DCS). 3. Ongoing discussion of complaints at regular clinical manager's meetings with the understanding that managers will use the discussion for educational purposes at team meetings.	Mary Nicholson, DPS 11/15/07 Mary Nicholson, DPS 12/1/07 Mary Nicholson, DPS 12/1/07 11.16.07

	Corrective Action for ongoing monitoring The DPS will continue to monitor all complaints. The DPS will continue to review on a quarterly basis the complaint log for completeness of logged complaints. The DPS and administrative team at VNS are committed to providing quality care and excellent customer service. The philosophy of DPS and DCS is that all complaints are considered an opportunity to improve in both quality of care and/or customer service.	Mary Nicholson, DPS 12/31/07

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	337010	A. BUILDING _____ B. WING _____	C 10/13/2009

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G 000	INITIAL COMMENTS This statement of deficiencies is a result of a complaint investigation (NY00076990) conducted by the staff of the Western Regional Office of the New York State Department of Health on 10/13/09. During the investigation, three (3) clinical records were reviewed.	G 000	See attached.	
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on review of three (3) clinical records and interview with agency staff, the agency failed to provide skilled nursing service or did not address all of the patient's nursing needs in one (1) of three (3) clinical records. Failure to provide nursing services has the potential for patients health status to be compromised. The patient affected is 2. Patient 2 - This [redacted] year-old patient with diagnosis that include surgical aftercare involving the muscloskeletal system, type II diabetes, diabetic neuropathy, morbid obesity, history of falls was admitted to the home care agency on 07/31/09. The patient received physical and occupational therapy home care services. The physical therapist documented in the plan of care for 07/31/09 to 09/28/09 that the patient was to received a Vitamin B-12 1000 micrograms injection at the physician's office on 08/18/09.	G 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Buchan DPS | TITLE | (X6) DATE: 11/10/09

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G 157	Continued From page 1 On 08/07/09, the physical therapist documented that the patient was "I (independent) with some difficulties w/ rw (rolling walker)...movement/steps slow...intermittent shuffling seen...ambulated approx 22-25 ft (feet) x2... did rest halfway...sob (shortness of breath) w/ (with) min (minimal)-mod (moderate) exertion...", "fatigued quickly today" "still showing some unsteadiness w/ ambulation". The next physical therapy visit was completed on 08/19/09. The physical therapist documented that the patient was "ambulating w/ rw...steps are short intermittent shuffling seen w/ steps... ambulated approx 20-22 ft x3...fatigued w/ steps...showed some unsteadiness w/ turns" "tolerated visit fair... fatigued quickly" "patient's pain slowing her overall mobility". There was no documentation in the patient record regarding the patient's ability to get out of the home on 08/18/09 for the Vitamin B12 injection ordered on the plan of care . According to the clinical record, the patient did not attempt to climbs stairs in and out of the home until 08/26/09. The physicial therapist documented the patient "tried going down 2 steps w/ rail in hallway...very difficult to complete especially going up". The physical therapist failed to inform the physician of the need for skilled nursing services to administer the Vitamin B12 injection ordered on the plan of care. During an interview with the Director of Patient Services and the Director of Corporate Complaince on 10/13/09, the Director of Patient Services stated the physical therapist forgot about the order for Vitamin B12 injection ordered on the	G 157	See attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 157	Continued From page 2 plan of care.	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review and interview with agency staff, the agency failed to ensure in two (2) of three (3) clinical records that the staff followed the plan of care established by the physician. The issues are failure to provide physical therapy services at the amount ordered. Failure to follow the established plan of care has the potential to place agency patients at risk for improper or inadequate care. The patients affected are 1 and 2. Patient 1- This [redacted] year-old patient with diagnosis that include type 2 diabetes mellitus, lumbago, abnormality of gait was admitted to the home care agency on 08/29/09. The plan of care for the period 08/29/09 to 10/27/09 contained orders for physical therapy "12 every 9 weeks 1". As of 10/13/09, the clinical record contained documentation of one (1) physical therapy visit completed on 08/31/09. The clinical record did not contain documentation explaining the lack of continued physical therapy services for this patient. The Physical Therapist (PT) did not follow the plan of care and did not inform the physician of a need to revise the plan of care. Patient 2 - This [redacted] year-old patient with diagnosis that include surgical aftercare involving the	G 158	See attached.	

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G 158	Continued From page 3 musculoskeletal system, type II diabetes, diabetic neuropathy, morbid obesity, history of falls was admitted to the home care agency on 07/31/09. The plan of care for the period 07/31/09 to 09/29/09 contained physician orders for physical therapy "16 every 9 weeks 1; 1 as needed 1". The clinical record contained documentation for thirteen (13) physical therapy visits during the period of 07/31/09 to 09/29/09. The clinical record lacked documentation to explain the missed physical therapy visits. The PT did not follow the plan of care and did not inform the physician of a need to revise the plan of care. During an interview with the Director of Patient Services and Director of Corporate Compliance on 10/13/09, the Director of Patient Services (DOPS) reported that the PT was having difficulties gaining access into Patient 1's home. The DOPS acknowledged the record lacked documentation that the physician was informed of the problem. No explanation was provided regarding the missed PT visit for Patient 2.	G 158	See attached.	
G 161	484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. This STANDARD is not met as evidenced by: Based on a review of three (3) clinical records and interview with agency staff, two (2) of three (3) patient records lacked evidence that physical therapy orders contain a frequency of visits that ensures that patient's current and ongoing needs were met. Failure to ensure that the physical therapy plan of care is complete has the potential	G 161		

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G 161	Continued From page 4 for unmet rehabilitative needs. The patient affected are 1 and 2. Patient 1- This [redacted] year-old patient with diagnosis that include type 2 diabetes mellitus, lumbago, abnormality of gait was admitted to the home care agency on 08/29/09. The plan of care for the period 08/29/09 to 10/27/09 contained orders for physical therapy "12 every 9 weeks 1". The clinical record did not contain physician orders that include the frequency of physical therapy visits. Patient 2 - This [redacted]ear-old patient with diagnosis that include surgical aftercare involving the muscloskeletal system, type II diabetes, diabetic neuropathy, morbid obesity, history of falls was admitted to the home care agency on 07/31/09. The plan of care for the period 07/31/09 to 09/29/09 contained physician orders for physical therapy "16 every 9 weeks 1; 1 as needed 1". The clinical record did not contain physician orders that include the frequency of physical therapy visits. Interview with the Director of Patient Services and Director of Corporate Compliance on 10/13/09, the Director of Patient Services acknowledged that the physical therapy orders were not complete to include the frequency of therapy services. The Director of Patient Services reported that all therapist were recently instructed in the proper method to write the visit frequency for therapy services.	G 161	See attached.	

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G157	**Acceptance of the Plan of Care** **Patient #2** 10/15/09 VNS contacted physician to offer SN to provide B12 injections. Physician refused stating B12 may be discontinued. Patient is now at baseline and rehab services closed as of 11/6/09. No further follow up. Therapist was counseled on requirement to provide comprehensive plan of care for patients and assess that all patient needs are met, including verification of medication. In addition, therapist was counseled on the requirement to document how the patient's needs were going to be met. **Identification of other Patients** VNS developed comprehensive case conference tool to be used by Clinical Team Managers. This includes a review of the plan of care and an assessment that all needs are met, including other services. Therapy managers will case conference using the VNS standards for case conferencing on at least 5 patients per week (25) per month. During case conference, if needs are identified, other services will be referred as needed. VNS will develop a report that identifies therapy only cases that include an injectable medication in its med profile. These patients's record will be reviewed to assure that the medication needs of the patient are being met and documented. SN will be referred as needed. **Control Measures** Results of case conferencing will be shared with individual staff for immediate follow up and corrective action as needed. Once a month, Therapy managers will meet with Director of Patient Services and Corporate Compliance Officer to review findings from case conferences and develop corrective actions as needed. **Quality Measures** VNS continues to review approximately 60 records per month. Results will be shared with individual staff and appropriate follow up action items, including but not limited to counseling, education, documentation correction, communication with MD and other disciplines with adjustments in the plan of care as needed. Record review results will be shared with Quality and compliance Committee (PAC) on a quarterly basis. Once a month, Therapy managers will meet with Director of Patient Services and Corporate Compliance Officer to review findings from case conferences and develop corrective actions as needed. Identification of trends will be used to develop further education and/or plans for improvement.	Jane Greer DPT, 10/22/09 Jane Greer, Susan Pucko, 11/9/09 and ongoing Jane Greer, Susan Pucko, 11/23/09 and ongoing Mary Nicholson DPS, Kathleen Cantaben CO, beginning week of 11/16/09 Mary Nicholson DPS, Kathleen Cantaben CO, ongoing 
G 158	**Care Follows a written plan of care that is periodically reviewed** **Patient #1**	

Case was closed to Rehab after therapy was unable to arrange a visit. MD was notified. SN has since re-referred therapy and secondary admission occur on 11/5/09.

Patient #2

10/15/09 VNS contacted physician to offer SN to provide B12 injections. Physician refused stating B12 may be discontinued. Patient is now at baseline and rehab services closed as of 11/6/09. No further follow up.
Upon interview with therapist, it was stated that pt often refused visits. The record was annotated on 10/13/09 to indicate that calls were made and the patient had refused.

Therapist was counseled on;

- Writing correct visit frequencies that meet the needs of the patient.
- Communicating with primary case manager on plan of care for the patient
- The requirement to follow the written plan of care and inform the physician of the need to revise the plan of care.
- The requirement for documenting communication with the interdisciplinary team, physician and the patient.

Jane Greer DPT, 10/22/09

Identification of other patients

VNS developed comprehensive case conference tool to be used by Clinical Team Managers. This includes a review of the plan of care and an assessment that all needs are met, including other services. Therapy managers will case conference using the VNS standards for case conferencing on at least 5 patients per week (25) per month. Managers will review record for evidence that the physician was notified for changes in the plan of care.

Jane Greer, Susan Pucko 11/9/09 and ongoing

Control Measures

Results of case conferencing will be shared with individual staff for immediate follow up and corrective action as needed. Once a month, Therapy managers will meet with Director of Patient Services and Corporate Compliance Officer to review findings from case conferences and develop corrective actions as needed.

Mary Nicholson DPS, Kathleen Cantaben CO, beginning week of 11/16/09

Quality Measures

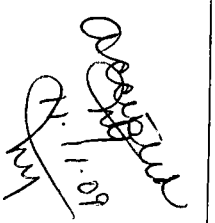
VNS continues to review approximately 60 records per month. Results will be shared with individual staff and appropriate follow up action items, including but not limited to counseling, education, documentation correction, communication with MD and other disciplines with adjustments in the plan of care as needed.

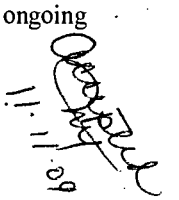
Mary Nicholson DPS, Kathleen Cantaben CO, ongoing

Record review results will be shared with Quality and compliance Committee (PAC) on a quarterly basis.

Once a month, Therapy managers will meet with Director of Patient Services and Corporate Compliance Officer to review findings from case conferences and develop corrective actions as needed.

Identification of trends will be used to develop further education and/or plans for improvement.



G161	**Orders for Therapy services are specific** **Patient # 1** Case was closed to Rehab after therapy was unable to arrange a visit. MD was notified. SN has since re-referred therapy and secondary admission occurred on 11/5/09. VNS will assure that new written orders include a visit frequency that meets the needs of the patient. **Patient # 2** Physical therapy recert plan of care (9/29/09) indicated an accurate visit frequency of 1x week 9. Therapy has since discharged as patient is baseline and stable. Therapist was counseled on; Writing correct visit frequencies that meet the needs of the patient. **Identification of other patients** VNS developed comprehensive case conference tool to be used by Clinical Team Managers. This includes a review of the plan of care and an assessment that all needs are met, including other services. Therapy managers will case conference using the VNS standards for case conferencing on at least 5 patients per week (25) per month. Managers will review orders for correct visit frequencies. Rehab clinicians instructed that the visit frequencies must be meaningful and reflect the needs of the patient. Therapy managers instructed staff to immediately begin using accurate visit frequencies in orders. In addition, each therapist was instructed to review the frequencies for their patients for improper frequencies and correct as needed. This will be completed by 11/6/09. **Control Measures** Results of case conferencing will be shared with individual staff for immediate follow up and corrective action as needed. Once a month, Therapy managers will meet with Director of Patient Services and Corporate Compliance Officer to review findings from case conferences and develop corrective actions as needed. **Quality Measures** VNS will audit approximately 10% of therapy records for evidence that visit frequencies are written to reflect patient needs. VNS continues to review approximately 60 records per month. Results will be shared with individual staff and appropriate follow up action items, including but not limited to counseling, education, documentation correction, communication with MD and other disciplines with adjustments in the plan of care as needed. Record review results will be shared with Quality and compliance Committee (PAC) on a quarterly basis. Once a month, Therapy managers will meet with Director of Patient Services and Corporate Compliance Officer to review findings from case conferences and develop corrective actions as needed.	Jane Greer, DPT 11/6/09 Jane Greer DPT, 10/22/09 Jane Greer DPT CTM, Susan Pucko CTM 11/9/09 and ongoing Jane Greer DPT CTM, Susan Pucko, CTM 11/6/09 Mary Nicholson DPS, Kathleen Cantaben CO, beginning week of 11/16/09 Kathleen Cantaben, CO, 11/20/09 Mary Nicholson DPS, Kathleen Cantaben CO, ongoing 

	Identification of trends will be used to develop further education and/or plans for improvement.	

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G 000	INITIAL COMMENTS This Statement of Deficiencies is the result of a complaint investigation #NY00071051 conducted by staff of the Western Regional Office of the New York State Department of Health on April 27, 2009. Three (3) patient records were reviewed.	G 000	See attached.	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on findings in two(2) of three (3) clinical records reviewed and staff interviews, care was not provided accordance with the plan of care. The issues are dressing changes not done as ordered and use of a Texas catheter without an order. Failure to follow the plan of care creates the potential for agency staff to act on inaccurate information that could result in the provision of improper care. This affected patients 1 and 3. The findings are: Patient 1 - This [redacted] year-old male was admitted to the home care agency on 09/20/08 with diagnoses of decubitus ulcer. The plan of care (POC) from 03/19/09 to 05/17/09 identified goals that "the patient/caregiver will demonstrate ability to perform dressing change using proper technique". On 03/20/09 a new wound order was obtained to use Calcium Alginate and foam for the dressing change until 03/27/09. The skilled nursing visit for 03/22/09 documented that the wound was	G 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Victoria A. Amos — TITLE: President CEO — (X6) DATE: 10/2/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 158	Continued From page 1 dressed with foam. The 03/23/09 skilled nursing notes included documentation that Hydrofiber rope and foam was used for the dressing change. During a telephone interview on 04/27/09, the wound care supplier (ConvaTec) Wound Ostomy Care nurse (WOCN) confirmed that Hydrofiber rope was not the same wound dressing as the Calcium Alginate. There was no evidence of documentation in the clinical record from 03/19/09 to 04/27/09 that nursing had instructed or observed dressing changes performed by the caregiver. Interview with the Community Health Nurse on 04/27/09 confirmed that the incorrect wound dressing was used between 03/20/09 to 03/27/09 by the nurse and the patient's spouse and that there was no teaching or observation by nursing while the caregiver provided the dressing change. Interview with the Director of Patient Services on 03/27/09 confirmed the findings. The POC from 03/19/09 to 05/17/09 under the skilled nursing observation and assessment included "straight cath (catheterize) three times a day wife independent". The skilled nursing OASIS recertification on 03/16/09 identified under MO520 "patient requires a urinary catheter". On 03/18/09 nursing documented "straight cath (catheterize) once daily" and that "VN instructed patient caregiver to always use Texas Catheter or change dressing when saturated to avoid further skin breakdown". The skilled nursing note on 03/23/09 documented patient use of a Texas Catheter. There was no evidence in the clinical	G 158	See attached.	

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G 158	Continued From page 2 record that the plan of care addressed the use of a Texas catheter. Patient 3 - This [redacted]year-old patient was admitted to the home care agency on 11/22/08 with diagnoses that included decubitus ulcer stage IV, hypertension and DVT (deep vein thrombosis). The plan of care (POC), dated 03/22/09 to 05/22/09 directed to nursing to cleanse the wound with normal saline, pack with Aquacel, cover with adhesive foam and to be performed 1 (one) to 3 (three) times per week and PRN (as needed) for stroke through drainage. Review of the skilled nursing visits for 03/17/09, 03/19/09, 03/24/09, 03/27/09 and 03/31/09 included documentation that the home care nurse cleansed the wound with saline and applied Aquacel Ag (silver) and covered with foam. Interview the home care nurse on 04/27/009 determined that the dressing uised was not ordered on the plan of care. Interview with the Director of Patient Services 04/27/09 agreed that the incorrect dressing was used on the decubitus ulcer.	G 158	See attached.	
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and interview with agency staff in one (1) of three (3) clinical records, agency staff failed to notify the physician of a change in the patient condition that may have resulted in changes to the plan of care (POC). The issues are failure to notify the physician for change in wound condition. There	G 164		

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G 164	Continued From page 3 is the potential for complications to occur by not alerting the physician. This affect patient 3. Patient 3 - This [redacted] year-old patient was admitted to the home care agency on 11/22/08 with diagnoses that included decubitus ulcer stage IV, hypertension and DVT (deep vein thrombosis). The plan of care for the period of 03/22/09 to 05/22/09 directed the nurse to perform dressing changes to the sacral decubitus using normal saline to cleanse the wound, pack with Aquacel and cover with adhesive foam one (1) to three (3) times per week and PRN (as needed). On 03/17/09, 03/19/09, 03/24/09, 03/27/09 and 03/31/09 skilled nursing documentation identified that Aquacel Ag was used for the sacral decubitus dressing changes. There was no documented evidence in the patient record than an order was obtained for the use Aquacel Ag. The skilled nursing visits from 04/03/09 to 04/10/09 included dressing changes with Aquacel. Skilled nursing visits for the following dates included wound measurements of the stage IV sacral decubitus as follows: 03/31/09 Sacral wound size: 0.5 cm (centimeter)x 0.5 cm x 0.6 cm, with serous drainage 04/03/09 Sacral wound size: 0.5 cm x 0.5 cm x 0.7 cm, drainage amount 3x3 foam serosanguinous 04/07/09 Sacral wound size: 0.5 cm x 0.4 cm x 0.5 cm, 5 cm by 5 cm drainage serous (dressing had fallen off) 04/10/09 Sacral wound size: 0.5 cm x 0.4 cm x 0.8 cm, 5 cm by 3 cm serosanguinous drainage	G 164	See attached.	

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G 164	Continued From page 4 0414/09 Sacral wound size: 0.5 cm x 0.5 cm x 0.8 cm, packing saturated into foam, serosanguinous Review of the clinical record lacked evidence that the physician was consulted related to the increased wound depth and increased wound drainage. Interview with the primary home care nurse on 04/27/09 confirmed that the Aquacel Ag was used for some of the dressing changes and not the Aquacel as ordered and that the doctor was not notified. Additionally the nurse stated that the sacral decubitus wound was "always a challenge to measure", that sometimes the smell was pungent but did not document this information", and that the physician was not notified of the change in wound depth because the nurse thought that this was not a concern. Interview with home care agency Wound Care Specialist on 04/27/09 stated that the "Aquacel dressing goes on a fiber and is a seaweed derivation". The exudate will make the dressing smell and if saturated will produce an odor". Telephone interview with Aquacel Manufacturer (ConvaTec) representative Wound Ostomy Care Nurse (WOCN) specialist on 04/27/09 included that "the dressing for Aquacel does not produce an odor. If a wound is infected, then there would be an odor present." On 04/16/09, the patient was admitted to the hospital due to increased lethargy, falls, increased lower back pain and per the admitting physician documentation "patient notes that her sacral wound has increased foul order and bloody drainage over the last week".	G 164	See attached.	

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G 164	Continued From page 5 As a result of the hospital record review, it was determined that the patient had acquired a wound infection and that the physician had not been notified.	G 164	See attached.	

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G158	**Acceptance of the Patient's Plan of Care** **Patient Corrective Action Plan** Patient # 1 Wound order was for Calcium alginate and foam on 3/20/09. On 2 visits 3/22/09 and 3/23/09, documentation does not state that correct wound product was used. Documentation does not support that the spouse was instructed on the alternative dressing change while the vac was on hold. Patient's Plan of Care included orders for straight catheterization 3x daily. On 3/18/09 nurse documented that the spouse was to straight cath 1x daily and instructed caregiver to use a Texas Catheter that was not included in the Plan of Care. Conference will occur with RN who visited on 3/22/09 to re-educate on assuring that correct wound products are used and documented by 10/17/09. Conference will occur with LPN who visited on 3/23/09 to re-educate on assuring that correct wound products are used and documented by 10/17/09. LPN will be re-educated to instruct patients and caregivers on the correct wound products when they are independent with the care. The spouse was familiar with how to manage the patient's wound from past history in the record. LPN will be re-educated on documenting patient care according to orders: no order for a Texas Catheter. Conference will occur with RN who visited on 3/18/09 to re-educate on documenting and teaching according to the Plan of Care by 10/17/09. Patient is now closed to VNS, no further follow up required. Patient # 3 Wound care ordered was to cleanse with normal saline, pack with Aquacel and cover with adhesive foam. On 5 visits RN documented use of Aquacel Ag, no Aquacel. Conference occurred with RN who used incorrect wound product occurred on 4/21/09 that included re education on assuring that the orders, as stated, are used and documented. **Identification of Other Patients** VNS has developed a report that identifies by ICD – 9 code active patients with wounds. This report is sorted by team and distributed to Clinical Team Managers (CTMs) weekly. CTMs are expected to use this report in preparations of case conferences in order to assure that wound care is done according to the plan of care. Approximately 60 record reviews are done each month. Following the Plan of Care is an audit item. Any patient record that does not have documentation to support that the plan of care was followed has immediate follow up by the CTM with the staff involved.	Susan Pellegrino, CTM 10/17/09 Susan Pellegrino, CTM 10/17/09 Susan Pellegrino, CTM 10/17/09 Susan Pellegrino, CTM 10/17/09 Brenda Bartock Director of Specialty Program, 9/16/09 complete Mary Nicholson DPS, ongoing

	Control Measures The results of the patient record reviews will be shared with individual staff and appropriate follow-up actions taken, including, but not limited to counseling, staff education, documentation correction, communication with MD/other disciplines with as needed adjustments in the plan of care. Mandatory Condition of Participation (COP) training occurred with all staff in February 2009. This included following the plan of care. CTMs have/will review the COP training with all staff in team meetings. COP training has been added as a regular orientation class beginning in March 2009 that includes following the plan of care. Reeducation has/will occur on documentation of wounds and following the plan of care by 10/17/09 **Quality Measures** The results of the patient record reviews will be shared with individual staff and appropriate follow-up actions taken, including, but not limited to counseling, staff education, documentation correction, communication with MD/other disciplines with as needed adjustments in the plan of care. The audit results have been and will be shared with the Quality and Compliance committee (PAC) on a quarterly basis. VNS will develop a focused audit on wound documentation and following the plan of care for wounds. Identification of trends will be used to develop further education and/or plans for improvement.	Mary Nicholson DPS, 10/17/09 Mary Nicholson DPS, 10/17/09 Mary Nicholson DPS, 10/17/09 Brenda Bartock Director of Specialty Program, 10/17/09 Mary Nicholson DPS, ongoing Kathy Cantaben, ongoing Kathy Cantaben, 10/30/09
G164	**Periodic Review of the Plan of Care** Patient # 3 Wound measurements and drainage changed on numerous visits from 3/31/09 – 4/14/09. The record did not include documentation of physician notification of this change. Interview with WOCN on 10/1/09 to clarify statement about Aquacel. WOCN stated that Aquacel is a fiber and it is not a seaweed derivative. Alginate is a fiber that is a seaweed derivative. DPS recalls that this conversation included a discussion about alginate. The CTM stated that she had thought the wound care was alginate. WOCN responded to this stating that alginate could have an odor because of its' seaweed component. Once the wound dressing was clarified, WOCN stated she remembers then discussing Aquacel, which was the package insert provided during the DOH interview. WOCN stated that wounds that have packing can have odors from the exudates, that is not necessarily indicative of a wound infection. Staff interviews include that the changes in the wound measurements and drainage were not considered significant. Patient had a stage 4 slow healing decubitus. Staff did not consider that these minor changes were a significant change in condition. In addition, even though the patient had a confirmed wound infection upon admission to the hospital, there were no signs or	

	symptoms of infection on the previous visit prior to admission to the hospital. It was reported that the patient had fallen at least twice in the home, without notifying VNS and went to the hospital because of a fall. The trauma to the wound secondary to the falls compromised the wound healing status and may have contributed to the development of the infection. Of note, the case manager was actively working the patient and the family to find an alternative higher level of care and upon resumption of care, this patient is now in an assisted living facility.	
	A record review will be completed from the time of the resumption of care to assure that the plan of care is appropriate, accurate and the MD was notified of any changes in status.	Sue Pellegrino, CTM 10/17/09
	Identification of Other Patients	
	Approximately 60 record reviews are done each month. MD notification of changes that may require a change in the POC is an audit item. Any patient record that does not have documentation to support that MD was notified of a potential change has/will have immediate follow up by the CTM with the staff involved.	Mary Nicholson DPS, ongoing
	Control Measures	
	The results of the patient record reviews will be shared with individual staff and appropriate follow-up actions taken, including, but not limited to counseling, staff education, documentation correction, communication with MD/other disciplines with as needed adjustments in the plan of care.	Mary Nicholson DPS, ongoing
	Mandatory Condition of Participation (COP) training occurred with all staff in February 2009. This included the requirement to notify the MD with changes in the plan of care. CTMs have/will review the COP training with all staff in team meetings.	Mary Nicholson DPS, 10/17/09
	COP training has been added as a regular orientation class beginning in March 2009 that includes following the plan of care.	Mary Nicholson DPS, ongoing
	Quality Measures	
	The results of the patient record reviews will be shared with individual staff and appropriate follow-up actions taken, including, but not limited to counseling, staff education, documentation correction, communication with MD/other disciplines with as needed adjustments in the plan of care.	Mary Nicholson DPS, ongoing
	The audit results have been and will be shared with the Quality and Compliance committee (PAC) on a quarterly basis.	Kathy Cantaben, ongoing
	VNS will develop a focused audit on wound documentation and following the plan of care for wounds and notification to the MD with significant changes in wound condition that may necessitate a change in the plan of care. Identification of trends will be used to develop further education and/or plans for improvement.	Kathy Cantaben, 10/30/09

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	337267	A. BUILDING _____ B. WING _____	07/28/2009

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PARK RIDGE AT HOME LTHHCP	2300 BUFFALO ROAD BUILDING 400 ROCHESTER, NY 14624

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G 000	INITIAL COMMENTS This statement of deficiencies is a result of the Title XVIII/XIX, Article 36 partially extended recertification survey and complaint investigation (NY00074508) conducted by the staff of the Western Regional Office of the New York State Department of Health on 07/20/09, 07/21/09, 07/22/09, 07/23/09, 07/24/09, 07/27/09 and 07/28/09. During the survey, sixteen (16) clinical records were reviewed and six (6) home visits were conducted.	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy, and interview with agency staff, nine (9) of sixteen (16) clinical records evidence is lacking that there is a mechanism for effectively communicating changes in the patient's condition between disciplines and at case conferences. The issues are lack of coordination regarding the patient's PERS (Personal Emergency Response System) unit, telehealth readings, change in skin status, provision of aide service, need for social day care, and changes in the plan of care (POC). Lack of adequate coordination of care and case management has the potential for unmet patient needs and possible negative patient outcomes. Patients 5, 6, 7, 8, 9, 10, 13, 15 and 16 are affected.	G 144	Attachment #1	9-1-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Vice President, HCBS | 8/20/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 Examples include: Patient 13 - This [redacted] year-old patient with diagnoses that include total hip replacement, aftercare of joint replacement, morbid obesity and methicillin resistant staphylococcus aureus was admitted to the agency on 03/26/09. The plan of care for the period from 03/26/09 to 05/24/09 included nursing to visit two (2) to three (3) times a week for one (1) week, then one (1) to two (2) times a week for eight (8) weeks with four (4) as needed visits. This plan of care also included orders for Home Health Aide (HHA) services for two (2) to three (3) times a week for nine (9) weeks. A supplemental order, dated 04/27/09, was written by the Registered Nurse and signed by the physician to increase the HHA visit frequency to five (5) to seven (7) times a week for four (4) weeks. On 05/02/09, 05/05/09 and 05/08/09, the HHA documented in the aide activity record that the patient refused a sponge bath because the patient "was in pain", "too much pain" and "was in a lot of pain". The aide care plan, dated 03/26/09, instructed the HHA to "alert CHN (Community Health Nurse) of any concerns". The aide failed to alert the CHN of the patient's complaints and the inability to follow the aide care plan. The patient was subsequently rehospitalized on 05/10/09 with pneumonia. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings. HV Patient 8 -This [redacted] year-old patient, with diagnoses that include diabetes mellitus, long term use of insulin, hypertension, congestive heart disease and [redacted] was admitted to the agency on 04/23/09. The	G 144		

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G 144	Continued From page 2 clinical record was reviewed for the certification period from 06/22/09 to 08/20/09. On 06/26/09 the physical therapist (PT) visited after receiving a telephone call that the patient has a red area on her fifth toe. The Physical Therapist documented, "When socks and shoes were removed, foot was noted to have some edema in the dorsal mid foot, sock seam impression with redness across all toes, and small area on fifth digit that looks like the beginning of a corn. Redness and seam impression resolved within 15-20 minutes except for a 5-8 millimeter (mm) diameter circle on dorsum of first toe. The PT also documented. "Messages left for Sue (CHN) and GAIL (PT) to notify of findings and POC (Plan of Care)." The first nursing visit, following the report made by PT to the nurse, occurred on 07/06/09. The clinical record lacked evidence that the nurse on 07/06/09 at 9:28 AM addressed the past history of the reddened areas on the right foot or the compliance with recommendations made by the physical therapist. Physical Therapy also visited the patient on 07/06/09. PT documented in regards to the visit, "She (the patient) having difficulty with her shoes again. She has some redness over the fifth ray. Pt (patient) is again wearing very thick socks. She states she does not have thinner socks. Agreed to buy pt socks. Pt currently wearing sandals which her feet slide out of. Agreed to help shop for closed toe sandals to better support patient's feet." The clinical record lacked documentation that PT communicated with the nurse regarding the continuing issue of reddened toes. On 07/08/09, the Home Health Aide notified the Physical Therapist that the patient's right great toe had a "spot of pressure" on it. The PT documented, "Purchased thinner socks for pt and additional shoes (extra wide/depth) and brought to the patient." The	G 144		

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G 144	Continued From page 3 clinical record lacked documentation that the physical therapist and the nurse were in communication regarding the continuing issue of the reddened right foot. On 07/10/09 the nurse visited the patient after receiving a call from the home health aide reporting, "the client was 'dizzy and had loose stool". CHN (Community Health Nurse) made visit." The clinical record lacked evidence that the patient was assessed for compliance in wearing the appropriate shoes or socks. The nurse documented the patient's skin integrity as "intact" and skin character as "normal". The nursing note for 07/17/09 indicated that the patient was evaluated in the emergency room on 07/11/09 "for right foot pain, was to see her vascular MD (medical doctor) and sent home with ABT (antibiotic). Monday (07/13/09) Dr. saw her (the patient) opened the blisters and told her to put the ABT ointment on them (the toes) daily and cover with a Band-Aid." The "Monthly Case Conference" notes were reviewed as part of the clinical record. The conference date of 07/09/09 indicated under "Changes", "Telehealth in now." And under "Issues/Concerns/Goals", NU (nutritionist) continuing for weight issue." The case conference was signed by the clinical manger/supervisor and the nurse and lacked any notation regarding the reddened areas on the right foot or the participation of PT. The agency policy "Client Care Conferences" last revised 08/08 states, "Purpose - To assure coordination of all services rendered to clients of the Long Term home Health Care Program. To update multidisciplinary plans of treatment. 3. Each staff member present who provides service to the client being discussed will verbally present	G 144		

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G 144	Continued From page 4 a summary of progress noted to date, initial plan and/or revision in the client care plan and long and short term goals." During the home observation made on 07/20/09, the patient discussed her health buddy, the telehealth program, with the therapist. The clinical record lacked documentation that the patient was utilizing the telehealth program. After the surveyor presented this finding, the Director of Park Ridge at Home provided the Daily Telemonitoring Review Log and the Daily Compliance Report. Review of the Daily Telemonitoring Review Log and the Daily Compliance Report starting 06/26/09, indicated the patient was not performing use of the telehealth daily as expected. There were no readings taken 06/27/09 and 06/28/09, this was not discovered until 06/29/09. Interview with the Director of Park Ridge at Home on 07/23/09 reported that this is the responsibility of the nursing supervisor to evaluate the telehealth report and to notify the nurse, but the report is not checked on a daily basis. The Director further reports that the telehealth program has been in place since 2006 and does not have a policy regarding the telehealth program. The patient had a "high" reading on 07/06/09, and the reading was not observed/addressed until 07/08/09 by the supervisor, with a lack of notification/coordination to the nurse. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 provided no additional documentation to refute the findings.	G 144		

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G 144	Continued From page 5 Patient 10 - This [redacted]-year-old patient, with diagnoses that include circulatory disease, [redacted] and hypertension, was admitted to the agency on 02/09/08. The nurse documented on the discharge/transfer assessment that the patient was admitted to the hospital on 05/19/09 for a small bowel obstruction. The nurse completed a resumption, of care on 05/22/09, and documented "Plan to continue SW (social worker), PT (physical therapy), and increase skilled nursing (SN) visits for a short time to monitor bowel status." The PT visited on 05/26/09 and documented, "Pt (patient's) energy is very low as she reports inability to eat a normal diet d/t (due to) abdominal discomfort." The clinical record lacked documentation regarding communication to the nurse regarding the patient's status. The next visit made by the nurse was made on 05/29/09, when the nurse and the social worker complete a joint visit to complete the recertification assessment. The clinical record lacked documentation that the nurse assessed the abdominal pain that the patient had experienced. The "SOC/ROC Case Conference" notes were reviewed as part of the clinical record. The conference date of 05/22/09 indicated under "Acute care need", "none". The case conference notations lacked documentation regarding the recent hospitalization for a small bowel obstruction or that PT was involved in the case conference. The case conference was signed that "Katie" provided the report as well as, the supervisor receiving the report. The agency policy "Client Care Conferences" last revised 08/08 states, "Purpose - To assure coordination of all services rendered to clients of the Long Term Home Health Care Program. To update	G 144		

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G 144	Continued From page 6 multidisciplinary plans of treatment. 3. Each staff member present who provides service to the client being discussed will verbally present a summary of progress noted to date, initial plan and/or revision in the client care plan and long and short term goals." The Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 provided no additional documentation to refute the findings.	G 144		
G 152	484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines. This STANDARD is not met as evidenced by: Based on a review of the Professional Advisory Committee (PAC) meeting minutes, agency policy and procedure, and interview of agency administrative staff, the Governing Body failed to ensure that the PAC had adequate representation among its membership. There is the potential that quality of care issues will not be identified or addressed due to lack of adequate professional input. Findings include: Review of the membership for the PAC for the years of 2008 and 2009 lacked representation of speech language pathology services,	G 152	Attachment #2	

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G 152	Continued From page 7 occupational therapy, and respiratory therapy on the committee. Review of the PAC minutes from 06/04/08 to 06/10/09 indicated that the medical social worker was not present for the PAC meeting on 06/04/08 and 09/03/08. Review of the PAC minutes from 06/04/09 to 06/10/09 indicated that the nutritionist was not present for the PAC meeting on 06/04/08, 09/03/08, 12/03/08, 03/11/09, and 06/10/09. The policy titled, "Professional Advisory Committee" (last reviewed 11/08) states, "The Governing Board of LTHHCP shall approve the Professional Advisory Committee membership, which will include at least the following: Agency/Administrator(s), One or more practicing physicians, One or more members knowledgeable about the health care needs of the community , One or more consumer representatives, One or more professional nurse members of the program staff, Representative service, and Therapy providers." Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 agreed the committee was not represented by all the professional disciplines that represent the services provided by the agency.	G 152		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review and interviews with agency staff, six (6) of sixteen (16) patients did not receive care as directed by their plan of care that was established by their physician. The	G 158	Attachment #3	

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G 158	Continued From page 8 issues are blood glucose ranges not evaluated, the home health aide not supervised every fourteen days, and disciplines not following the ordered frequency and duration. Failure to ensure that the plan of care is followed has the potential for unmet patients needs. Patients affected are 1, 7, 8, 9, 15 and 16. Examples include: Patient 8 - This [redacted]year-old patient with diagnoses that include diabetes mellitus with long-term use of insulin, hypertension, congestive heart disease and [redacted] was admitted to the agency on 04/23/09. The clinical record was reviewed for the certification period from 06/22/09 to 08/20/09. The plan of care directed the nurse to assess the endocrine status of the patient. The clinical record lacked evidence that the nurse evaluated blood glucose ranges taken and recorded by the patient. Nursing visits made on 07/06/09, 07/10/09 and 07/17/09 documented blood glucose levels taken at the time of the nursing visit. The skilled nursing assessment on 07/06/09 documented that the insulin/oral agent the patient was taking was "oral diabetic agent." The plan of care (POC) directed the use of lantus subcutaneous solution 100 units/ml 80 units daily subcut. and humalog subcutaneous solution 100 units/ml administered by sliding scale. All nursing visits made lacked evidence that the nurse assessed the frequency and dosage of humalog insulin per sliding scale that was administered by the patient. The POC for the certification period from	G 158		

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G 158	Continued From page 9 06/22/09 to 08/20/09 directed the nutritionist to "Teach diabetic diet. Include instruction on 2gm sodium, low fat." The clinical notes prepared by the dietician for the visit made on 07/18/09 lacked documentation that the patient was instructed in her diabetic diet, or assessed regarding her food choices. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 provided no additional documentation to refute the findings. Patient 1 - This [redacted] year-old patient with diagnoses of Alzheimer's Disease with dementia, type II diabetes mellitus and hypertension, was admitted to the agency on 08/28/08. The plan of care (POC) for the certification period from 04/25/09 to 06/23/09 directed the nurse to "Notify MD of BG's (blood glucoses) <60 or >140 mg/dl." The recertification summary to the physician on 04/23/09 indicates the daughter takes the patient's blood glucose and administers the insulin. Skilled nursing visits made on 05/07/09, 05/22/09 and 06/05/09 lacked evidence that the blood glucose that the daughter was monitoring and recording were assessed. On 05/07/09 and 06/05/09 the nurse assessed only the blood glucose at the time of the visit. On 05/22/09 the nurse did not assess the blood glucose. A supplemental order dated 06/23/09 was sent to the physician stating, "Pt (patient) was discharged from PRAH (Park Ridge at Home) D/T (due to) hospitalized for UTI/Sepsis?Hyperglycemia, prior to hosp., BG (blood glucose) had been incr. (increased) to 200's in PM most of the time." The clinical record lacked documentation that the nurse had contacted the physician regarding the	G 158		

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G 158	Continued From page 10 patient experienced blood glucose of 200 mg/dl most evenings. The POC for the certification from 04/25/09 to 06/23/09 directed the nurse to supervise the home health aide (HHA) every 14 days. The patient was receiving HHA service 5-7 times a week. The nurse supervised the HHA on 05/07/09 and again on 05/22/09, fifteen days later. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 agreed the nurse failed to notify the physician that BGs in the evening were often >140 mg/dl. and supervise the HHA as ordered. Patient 16 - This [redacted] year-old patient with diagnoses that include cellulitis of the leg, peripheral vascular disease and arthropathy of the left leg was admitted to the agency on 04/18/09. The patient record contained supplemental physician order, dated 06/26/09 to "change una boots every three (3) days r (right) and l (left) leg." The clinical record lacked evidence that a skilled nursing visit was completed every three days. The nurse visited on 06/28/09 to change the una boots and not again until 07/02/09. The nurse then visited 07/05/09 to change the una boots and not again until 07/09/09. The registered nurse failed to follow the plan of care established by the physician on 06/26/09 to change the una boot to the right and left legs every three (3) days. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 confirmed these findings.	G 158		
G 159	484.18(a) PLAN OF CARE	G 159	Attachment #4	

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G 159	Continued From page 11 The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and agency staff interviews in seven (7) of sixteen (16) clinical records, the agency did not ensure that the plan of care (POC) was of sufficient scope to meet the patients' needs. The issues are: lack of orders for medications, complete diet regimes, as well as use of telehealth monitoring, respite, and PERS (Personal Emergency Response System). Without a complete POC there is the potential for agency staff to act on incomplete and/or inaccurate information, which could result in negative patient outcomes. The patients affected are 1, 6, 7, 8, 10, 11 and 13. Examples include: HV Patient 8 - This [redacted]-year-old patient with diagnoses that include diabetes mellitus with long term use of insulin, hypertension, congestive heart disease and [redacted] was admitted to the agency on 04/23/09. The clinical record was reviewed for the certification period from 06/22/09 to 08/20/09. The plan of care (POC) included an order for "humalog subcutaneous solution 100 units/ml prn	G 159		

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G 159	Continued From page 12 (as needed) subcut 70-150 6 units 151-200 8 units 201-250 10 units 301-360 14 units". The order lacked direction as to where and how frequently blood glucose measurements were to be taken to determine the need for the sliding scale insulin. During the home observation made on 07/20/09 the patient discussed her health buddy, the telehealth program, with the therapist. The POC lacked documentation that the patient was utilizing the telehealth program. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 confirmed the POC lacked specificity for the measurement of blood glucose levels and orders for the telehealth. HV Patient 11 - This [redacted]-year-old patient with diagnoses that include rheumatoid arthritis, type II diabetes mellitus and hypertension was admitted to the agency on 12/29/04. The plan of care (POC) for 06/06/09 to 08/04/09 did not contain information regarding a monthly infusion of Orencia the patient was receiving at her physician's office. During a home visit on 07/21/09 the patient stated she was receiving Orencia. The clinical summary, included on the POC for 06/06/09 to 08/04/09 stated, "client going for her infusion next visit at 9 am will do visit early." Upon interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09, it was acknowledged that the patient was receiving an Orencia infusion at her physician's office and the nurse failed to include this information in the POC. Patient 6 - This [redacted]-year-old patient with diagnoses that include type II diabetes mellitus,	G 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 159	Continued From page 13 hypertension and asthma was admitted to the agency on 03/11/09. The plan of care (POC) for 05/10/09 to 07/10/09 contained skilled nursing orders, "spouse will manage Coumadin dose per MD (medical doctor) instructions." This POC did not include dosage, frequency and route for Coumadin. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy, and interview with agency staff, four (4) of sixteen (16) clinical records lacked documentation that the physician was contacted by staff when the patient's condition changed. This has the potential to result in unmet patient needs and/or provision of improper care. This affected patients 1, 2, 8 and 13. Examples include: Patient 13 - This [redacted] year-old patient with diagnoses that include total hip replacement, aftercare of joint replacement, morbid obesity and methicillin resistant staphylococcus aureus was admitted to the agency on 03/26/09. The plan of care, developed for 03/26/09 to 05/24/09, contained skilled nursing orders to "assess wound changes every visit". On 04/14/09, the RN documented during a skilled nursing visit,	G 164	Attachment #5 Andrea Wolf 8-27-09	

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G 164	Continued From page 14 "According to the client seen by the surgical PA (physical assistant) recently. States large amount of drainage to the wound d/t (due to) "I have a lot of fluid in me'." The skilled nursing assessment of the right hip wound stated that a "large amount of serous drainage on old dressing". There is no evidence in the clinical record that the RN followed up with the surgeon to confirm this information. On 04/16/09, the RN documented "incision line slt (slightly) open distally". There is no evidence in the clinical record that the RN completed the wound measurements of the right hip incision during this skilled nursing assessment or informed the physician of changes in wound status or confirmed current wound care orders. On 04/28/09, the RN documented that there were two (2) areas of tunneling on the right hip incision. However, the clinical record does not contain evidence that the RN informed the physician of the changes in wound status or confirmed current wound care orders. The RN failed to follow agency policy (last revised 05/08) states, "Procedure: wound(s) will be assess every visit to include the following: 8. The CHN/RN is required to report to the MD (medical doctor) within the 24 hours and deterioration in existing wounds or the identification of a new wound." Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings. Patient 8 - This [redacted]year-old patient, with diagnoses that include diabetes mellitus with	G 164		

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G 164	Continued From page 15 long-term use of insulin, hypertension, congestive heart disease, and [redacted] was admitted to the agency on 04/23/09. The clinical record was reviewed for the certification period from 06/22/09 to 08/20/09. On 06/26/09 the physical therapist (PT) visited after receiving a telephone call that the patient had a red area on her fifth toe. The Physical Therapist documented, " When socks and shoes were removed, foot was noted to have some edema in the dorsal mid foot, sock seam impression with redness across all toes, and small area on fifth digit that looks like the beginning of a corn. Redness and seam impression resolved within 15-20 minutes (min), except for 5-8 millimeter (mm) diameter circle on the dorsum of first toe. The clinical record lacked evidence that the physical therapist notified the physician that the patient had developed reddened toes due to pressure. Physical Therapy also visited the patient on 07/06/09. Pt documented in regards to the visit, "She (the patient) is having difficulty with her shoes again. She has some redness over the fifth ray. Pt (patient) is again wearing very thick socks. She states she does not have thinner socks. Agreed to buy pt socks. Pt currently wearing sandals which her feet slide out of." On 07/08/09, the home health aide notified the Physical therapist that the patient's right great toe had "spot of pressure" on it. The clinical record lacked evidence that the physical therapist notified the physician that the patient was continuing with reddened toes due to pressure. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 provided no additional documentation to refute the findings.	G 164		

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G 164	Continued From page 16 Patient 1 - This [redacted]-year-old patient, with diagnoses of Alzheimer's Disease with dementia, diabetes mellitus type II, and hypertension, was admitted to the agency on 08/28/08. The plan of care for the certification from 04/25/09 to 06/23/09 directed the nurse to "Notify MD or BG's (blood glucoses) <60 or >140 mg/dl." The recertification summary to the physician on 04/23/09 indicates the daughter takes the blood glucose and administers the insulin. Skilled nursing visits made on 05/07/09, 05/22/09 and 06/05/09 lacked evidence that the blood glucose that the daughter was monitoring and recording were assessed. On 05/07/09 and 06/05/09 the nurse assessed only the blood glucose at the time of the visit. On 05/22/09 the nurse did not assess the blood glucose. A supplemental order dated 06/23/09 was sent to the physician stating, "Pt (patient) was discharged from PRAH (Park Ridge at Home) d/t (due to) hospitalized for UTI/Sepsis/Hyperglycemia, prior to hosp., BG (blood glucose) had been incr. (increased) to 200's in PM most of the time." The clinical record lacked documentation that the nurse had contacted the physician regarding the patient experiencing blood glucose of 200 mg/dl most evenings. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 agreed the nurse failed to notify the physician that BG in the evening were often >140 mg/dl.	G 164		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and	G 166	Attachment #6	

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G 166	Continued From page 17 dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy, and interview with agency staff, four (4) of sixteen (16) clinical records lacked evidence that orders were obtained for changes in the plan of care. The issues are failure to obtain orders for changes in medication regimes, a respiratory therapist evaluation, and a wound culture. The failure to obtain signed physician orders for changes in the plan of care has the potential for the agency staff to act on inaccurate information which may place the patient's health and welfare at risk. The patients affected are 2, 12, 13 and 16. Examples include: Patient 2 - This [redacted] year-old patient with diagnoses that include incomplete bladder emptying, coronary atherosclerosis and diabetes mellitus type II was admitted to the agency on 01/13/09. This record was reviewed as an adverse event due to an injury caused by a fall or accident at home for the time frame from 01/01/09 to 03/31/09. The Registered Nurse (RN) documented in the clinical record on 01/19/09 that the patient was not to take Plavix 75 mg one tablet daily by mouth. The patient went to the emergency department on 01/18/09 due to a nosebleed and had a nasal packing completed. The RN also documented that the patient received instruction to discontinue Aspirin	G 166		

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G 166	Continued From page 18 products until seen by her physician. The clinical record lacked documentation that supplemental orders were obtained to confirm these medication instructions with the physician. On 01/22/09, the RN documented in the patient record that she contacted the otolaryngologist, treating the patients for nosebleeds, to receive verbal instructions regarding the restart of the patient's Plavix prescription. The clinical record did not contain a supplemental order to confirm these instructions with the physician. And the nurse failed to update the patient medication list to document the stop and start of Plavix as she documented in her skilled visit notes. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings. Patient 13 - This [redacted] year-old patient with diagnoses that include total hip replacement, aftercare of joint replacement, morbid obesity and methicillin resistant staphylococcus aureus was admitted to the agency on 03/26/09. The plan of care, developed for 03/26/09 to 05/24/09, contained an order for Coumadin 7 mg daily by mouth. On 04/18/09, the Registered Nurse documented in a skilled visit note that the patient informed her that the "client told by MD (medical doctor) by phone to hold Coumadin this evening". There is no documented evidence in the clinical record that the RN confirmed these instructions with the physician and put these verbal orders in writing for a countersignature by the physician. The RN failed to follow agency policy "Medication Administration" last reviewed 08/08 states, under Item B: Medication and Solutions,General Information, "Any discrepancy and/or change in	G 166		

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G 166	Continued From page 19 medication shall be clarified via telephone call to the physician and a confirmation of verbal (CVO) order sent." Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings. Patient 16 - This [redacted] year-old patient with diagnoses that include cellulitis of the leg, peripheral vascular disease and arthropathy of the left leg was admitted to the agency on 04/18/09. On 06/19/09, the Registered Nurse (RN) documented during a skilled nursing visit that "Call (physician) office re (regarding) cellulitis on lower legs.... VO (verbal order) given by (physician) to take culture of the wound. There is no documented evidence in the clinical record that the RN put this verbal order in writing and obtained a countersignature by the physician. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 confirmed these findings.	G 166		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, and interview with agency staff, six (6) of sixteen (16) clinical records, agency staff failed to provide skilled nursing services in accordance with the plan of care as evidenced by the deficiencies under G 158. In all situations, there was a potential for negative outcome due to services not provided in accordance with orders set forth by the physician. The affected patients are 1, 8, 9, 13, 15 and 16.	G 170	Attachment #7	

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G 170	Continued From page 20 See G158.	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure, and interviews with agency staff, nine (9) of sixteen (16) clinical records the nurse failed to regularly re-evaluate the patient's nursing needs. The issues are the nurse did not assess skin integrity, wound status, pain status, diabetic status, as well as follow through with patient's lab work and telehealth results. Patients affected are 1, 5, 6, 8, 9, 10, 12, 13 and 16. Examples include: Patient 13 - This [redacted] year-old patient with diagnoses that include total hip replacement, aftercare of joint replacement, morbid obesity and methicillin resistant staphylococcus aureus was admitted to the agency on 03/26/09. The plan of care (POC) for the certification period from 03/26/09 to 05/24/09 directed the nurse to "assess wound for changes every visit". It also directed the nurse "DuoDerm to sacral/buttocks decubiti-change every 3 days/as needed-instruct husband" and "right hip incision-DSD (dry sterile dressing) each day and as needed-husband independent with care". At the start of care (SOC) visit on 03/26/09, the Registered Nurse (RN) documented that she was unable to assess the patient's sacral pressure ulcer because the patient was unable to tolerate standing for a	G 172	Attachment #8 8-27-09	

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G 172	Continued From page 21 sufficient period of time to allow the RN to assess the area. The next skilled nursing visit was completed on 03/28/09. During this visit, the RN instructed the husband on wound care to the coccyx and completed wound care to the right hip incision. The wounds were not measured and/or staged by the nurse. The clinical record lacked evidence that the nurse provided a complete nursing assessment of the sacral wound and right hip incision. The first time the sacral decubitus was assessed and staged by the nurse was on 03/31/09. On 04/07/09, the RN documented "sacrum is closed-no open areas-resolved. Placed DuoDerm to site for protective purpose only". Skilled nursing visits from 04/07/09 to 05/09/09 lacked documentation that assessments of the sacral area were made or if the DuoDerm remained in place for protective purposes. On 04/16/09, the RN documented "incision line slt (slightly) open distally". There is no evidence in the patient record that the RN completed the wound measurements of the right hip incision during this skilled nursing assessment or informed the physician of changes in wound condition. Skilled nursing visits were completed on 04/17/09, 04/18/09, 04/21/09 and 04/28/09 without any measurement of the right hip wound incision. There is no evidence in the patient record that the right hip incision was measured again until 05/05/09. On 04/20/09, the RN documented that the patient's husband was discharged from the hospital post Myocardial Infarct and placement of two (2) stents. The RN documented that the husband was requesting an increase in home	G 172		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 172	Continued From page 22 delivered meals for the patient and the continuation of aide service twice daily for the patient. The RN documented that she "questioned him re need for any more wound care supplies re-ran short on w/e (weekend)." However, there was no evidence that the nurse assessed the need to increase skilled nursing services to provide the patient with the right hip incision care due to her husband's recent cardiac event and procedure. On 04/28/09, the RN documented that there were two (2) areas of tunneling on the right hip incision. However, the patient record does not contain evidence that the RN informed the physician of the changes in wound status or confirmed current wound care orders. The RN failed to follow agency policy "Assessment and Reporting of Wounds" (last revised 05/08) states, "Procedure: wound(s) will be assess every visit to include the following: 1. Wound measurements will be in centimeters, noting length, width and depth and any undermining or tunneling if present." 7. The CHN (community health nurse)/RN will provide teaching on wound care, prevention, signs and symptoms of infection, wound healing and when to contact the CHN on each visit. The CHN will document in the clients's record what is taught and response from the client/caregiver. 8. The CHN/RN is required to report to the MD (medical doctor) within the 24 hours and deterioration in existing wounds or the identification of a new wound." Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings.	G 172		

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	337267	A. BUILDING _____ B. WING _____	07/28/2009

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PARK RIDGE AT HOME LTHHCP	2300 BUFFALO ROAD BUILDING 400 ROCHESTER, NY 14624

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G 172	Continued From page 23 Patient 8 - This [redacted]-year-old patient, with diagnoses that include diabetes mellitus with long-term use of insulin, hypertension, congestive heart disease, and [redacted] was admitted to the agency on 04/23/09. The clinical record was reviewed for the certification period from 06/22/09 to 08/20/09. On 06/26/09 the physical therapist (PT) visited after receiving a telephone call that the patient had a red area on her fifth toe. The Physical Therapist documented, " When socks and shoes were removed, foot was noted to have some edema in the dorsal mid foot, sock seam impression with redness across all toes, and small area on fifth digit that looks like the beginning of a corn. Redness and seam impression resolved within 15-20 minutes (min), except for 5-8 millimeter (mm) diameter circle on the dorsum of first toe. The PT also documented, "Messages left for Sue (CHN) and Gail (PT) to notify of findings and plan of care (POC)." The first nursing visit, following the report made by PT to the nurse, occurred on 07/06/09. The clinical record lacked evidence that the nurse on 07/06/09 addressed the past history of the reddened areas on the right foot or the compliance with recommendations made by the physical therapist. Physical therapy also visited the patient on 07/06/09. PT documented in regards to the visit, "She (the patient) is having difficulty with her shoes again. She has some redness over the fifth ray. Pt (patient) is again wearing very thick socks. She states she does not have thinner socks. Agreed to buy pt socks. Pt currently wearing sandals which her feet slide out of. Agreed to help shop for closed toe sandals to better support pt's feet." On 07/08/09, the home health aide notified the Physical therapist that the patient's right great toe had "spot of	G 172		

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G 172	Continued From page 24 pressure" on it. The PT documented, "Purchased thinner socks for pt and additional shoes (extra width/depth) and brought to patient." The clinical record lacked documentation that the nurse measured, documented, and staged the area on the reddened right foot, or educated the patient in regards to pressure relief in wearing appropriate socks and shoes. The RN failed to follow agency policy "Assessment and Reporting of Wounds" (last revised 05/08) states, "Procedure: wound(s) will be assess every visit to include the following: 1. Wound measurements will be in centimeters, noting length, width and depth and any undermining or tunneling if present." 7. The CHN (community health nurse)/RN will provide teaching on wound care, prevention, signs and symptoms of infection, wound healing and when to contact the CHN on each visit. The CHN will document in the clients's record what is taught and response from the client/caregiver. 8. The CHN/RN is required to report to the MD (medical doctor) within the 24 hours and deterioration in existing wounds or the identification of a new wound." On 07/10/09 the nurse visited the patient, the clinical record lacked evidence that the patient was assessed for compliance in wearing the appropriate shoes or socks. The nurse documented the patient's skin integrity as "intact" and skin character as "normal". The clinical record indicated that the patient was evaluated in the emergency room on 07/11/09 "for right foot pain, was to see her vascular MD (medical doctor) and sent home with ABT (antibiotic)". Monday (07/13/09) Dr. saw her (the patient) opened the blisters and told her to put the ABT	G 172		

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G 172	Continued From page 25 ointment on them (the toes) daily and cover with a Band-Aid." The clinical record lacked documentation that the nurse documented in the client's record that the dressing procedure was taught and response was received from client/caregiver. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 at 10 AM provided no additional documentation to refute the findings. Patient 12 - This [redacted]year-old patient with diagnoses that include chronic obstructive pulmonary disease, diabetes mellitus type II, long term use of insulin and arthritis. The plan of care for the certification period from 06/10/09 to 08/08/09 directed nursing to provide telehealth monitoring. The nurse was to notify the physician with systolic blood pressures of >160 or <90, diastolic blood pressure >100 or <50, pulse oximetry of <89% as well as weight gain of three (3) pounds in 24 hours or eight (8) pounds in one (1) week. After the surveyor presented that the record lacked documentation regarding the use of the telehealth by the patient, the Director of Park Ridge at Home provided the Daily Telemonitoring Review Log and Daily Compliance Report. Review of the Daily Telemonitoring Log and the Daily Compliance Report starting 06/01/09, indicated the patient's readings were not assessed on a daily basis. The readings taken on 06/06/09, 06/07/09, and 06/08/09 were not assessed until 06/08/09. The readings taken on 06/13/09, 06/14/09 and 06/15/09 were not assessed until 06/15/09. The readings taken on 06/24/09 and 06/25/09 were not assessed until 06/25/09. The readings were taken on 06/27/09,	G 172		

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G 172	Continued From page 26 06/28/09 and 06/29/09 were not assessed until 06/29/09. The readings taken on 07/04/09, 07/05/09, 07/06/09, and 07/07/09 were not assessed until 07/07/09. The readings taken on 07/11/09, 07/12/09 and 07/13/09 were not assessed until 07/13/09. Interview with the Director of Park Ridge at Home on 07/24/09 reported that it is the responsibility of the nursing supervisor to evaluate the telehealth report and notify the nurse, but the report is not checked on a daily basis. The Director further reports that the telehealth program has been in place since 2006 and does not have a policy regarding the telehealth program. The Daily Compliance Report lacked documentation that the patient was utilizing the telehealth program on a daily basis. The Daily Telemonitoring Review Log lacked documentation as to why the patient had not performed the assessment on a daily basis. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 at 10 AM provided no additional documentation to refute the findings.	G 172		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Nursing did not prepare clinical and progress notes, coordinate services, inform the physician and other personnel of changes in the patient's condition and needs for thirteen (13) of sixteen	G 176	Attachment #9	

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G 176	Continued From page 27 (16) patients as evidenced by the deficiencies under G144, G164 and G236. This practice has the potential to place all patients at risk for poor outcomes of care and unmet needs. This affected patients 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 13, 15 and 16. See G144, G164, G236.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure and interview with agency staff, five (5) of sixteen (16) clinical records evidence is lacking that the nurse counseled and/or taught the patient and caregivers skills needed to meet nursing and other related needs. The issues are the lack of counseling regarding wound care, urinary catheterization, and medication instruction. Failure to counsel the patient and/or family has the potential for unmet nursing needs and provision of poor quality of care. Patients affected are 6, 8, 9, 13 and 16. Examples are: Patient 13 - This [redacted] year-old patient with diagnoses that include total hip replacement, aftercare of joint replacement, morbid obesity and methicillin resistant staphylococcus aureus was admitted to the agency on 03/26/09. The plan of care (POC) for the certification period from 03/26/09 to 05/24/09 directed that the patient was to receive a dry sterile dressing daily and as	G 177	Attachment #10	

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G 177	Continued From page 28 needed to the left hip incision. The POC indicated that the patient's husband was "independent in a dry sterile dressing to right hip incision." The registered nurse (RN) assessed and completed wound care to the right hip incision during this start of care visit. The clinical record lacked evidence that the nurse observed the husband performing the dressing change. The agency policy, "Assessment and Reporting of Wounds" last revised 05/2008 states, "The CHN/RN (Community Health Nurse/Registered Nurse) will provide teaching on wound care, prevention, signs and symptoms of infection, wound healing and when to contact the CHN on each visit. The CHN will document in the client's record what is taught and response from the client/caregiver." According to the clinical record the patient went to stay with another family member on 04/16/09, while the patient's spouse was hospitalized. The RN documented in the visit note that the nurse was at the patient's home at the time the patient left with the family member. The RN documented she "briefed her (the family member) on mediset as prefilled for patient today and dressing change to hip incision." There was no evidence in the clinical record that the RN assessed this family member's ability to complete appropriate wound care to the right hip incision and offer counseling and/or education in regards to signs and symptoms of infection, wound healing and when to contact CHN. On 04/20/09 the RN documented that the patient's husband was recuperating at home following his post myocardial infarct and placement of two (2) stents. The husband was	G 177		

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G 177	Continued From page 29 completing the daily wound care to the right hip following his return home from the hospital. There was no evidence that the RN provided teaching regarding infection control measures due to patient's and husband's medical diagnoses and there was no evidence that the RN counseled the husband regarding the ability to increase the nursing visit frequency to complete the hip incision wound care during his recuperation. During an interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09, no additional information was provided to refute the findings. Patient 6 - This [redacted] year-old patient with diagnoses that include type II diabetes mellitus, hypertension and asthma was admitted to the agency on 03/11/09. The plan of care (POC) for 05/10/09 to 07/10/09 stated, "PT/INR (prothrombin time/international normalized ratio) drawn by ACM lab, who notified MD (medical doctor) regarding results, who notifies patient/spouse regarding med changes." The POC also stated, "spouse will manage Coumadin dose per MD instruction." The agency policy "Medication Administration" last reviewed 08/2008 states, "It is the policy of Park Ridge at Home (PRAH) that the medication regimens of all clients will be continuously monitored and evaluated through the length of service. The nurse through skilled assessment will identify therapeutic and non-therapeutic responses and any untoward effects of all medications. This includes medications administered by the nurse, the client, and/or the Primary Caregiver (PCG). The information will be communicated verbally and documented to other professional caregivers as necessary. All medications will be listed on	G 177		

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G 177	Continued From page 30 physician orders. The clinical record lacked evidence that the RN evaluated the PT/INR laboratory results and confirmed the Coumadin dosage with the physician's office in order to provide appropriate teaching/counseling regarding the medication use to the patient and spouse. During an interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 no additional information was provided to refute the findings. Patient 9 - This [redacted]-year-old patient with diagnoses that include multiple sclerosis and urinary retention was admitted to the agency on 04/24/07. The plan of care (POC) for 06/12/09 to 08/10/09 included orders for the patient to provide straight self-catheterization three (3) to four (4) times per day. The POC directed the nurse to assess for signs/symptoms of infection every visit and assess urinary functioning/renal status, with a short term goal for the patient to verbalize relief of urinary retention and the long term goal to be infection and complication free. On 06/19/09 the registered nurse (RN) documented the patient's voiding method is "toileting, incontinences." The clinical record lacked documentation that the nurse instructed the importance of self-catheterization and the need to evaluate the residual urine. On 07/01/09 the RN documented that the genitourinary observation and residual urine was "not assessed." The incomplete assessment resulted in a lack of teaching/counseling regarding the genitourinary system, which limits the patient's ability to achieve the nursing goals established for this patient. During an interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 no additional information was provided to refute the findings.	G 177		

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G 224	Continued From page 32 frequently would forget to do them. The nurse decided that the home health aide could assist her when they came three times per week. The aide care plan lacked documentation that the aide was to assist the patient in obtaining her telehealth monitoring. Interview with the Senior Director of Home Care Services, Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09 agreed that the aide care plan had not been updated to reflect the need to assist the patient with her telehealth monitoring. Patient 3 - This -year-old patient with diagnoses that include type II diabetes mellitus, congestive heart failure, ulcer of the mid foot and Vitamin B12 deficiency was admitted to the agency on 01/30/08. This record was reviewed as an adverse event for wound infection or deterioration wound status for the period from 01/01/09 to 03/31/09. The plan of care from 01/24/09 to 03/24/09 included orders for home health aide (HHA) services. The HHA documented on the activity record dated 02/02/09, 02/09/09, 02/16/09, 02/18/09, 03/05/09 and 03/09/09 that the patient was weighed. However, the aide care plan dated 01/23/09 did not include instructions for the HHA to weigh the patient. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed that the aide care plan should have included instructions to weigh the patient. Patient 4 - This -year-old patient with diagnoses that include dysphasia, coronary atherosclerosis and chronic obstructive pulmonary disease was admitted to the agency on 10/20/05. The plan of care for 06/01/09 to	G 224		

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G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure and interview with agency staff, five (5) of sixteen (16) clinical records lacked evidence that the nurse/therapist had completed comprehensive written instructions for the home health aide. The issues include the lack of information regarding assistance with telehealth, obtaining a patient's weight, medication reminders and provision of a home exercise program. The lack of complete information has the potential to result in the provision of improper care or the lack of care. This affected patients 3, 4, 6, 8 and 14. Examples include: [redacted] Patient 8 - This [redacted] year-old patient with diagnoses that include diabetes mellitus with long term use of insulin, hypertension, congestive heart disease and [redacted] was admitted to the agency on 04/23/09. The clinical record was reviewed for the certification period from 06/22/09 to 08/20/09. During the home observation on 07/20/09 the patient was discussing her telehealth monitoring system with the physical therapist. The patient reported to the surveyor that she was to perform the telehealth readings on a daily basis, but she	G 224	Attachment #11	

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G 224	Continued From page 33 07/30/09 included an order for home health aide (HHA) services. The HHA documented on the all aide activity notes on both the morning and evening shifts from 06/01/09 to 07/10/09 that the HHA completed medication reminders. The aide care plan dated 05/27/09 did not include instructions for the HHA to complete a medication reminder. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/22/09 confirmed that the aide care plan should have included a medication reminder.	G 224		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy, home observation and interview with agency staff, evidence is lacking in four (4) of sixteen (16) clinical records that home health aide supervisory visits are conducted every fourteen (14) days. Failure of the agency to provide adequate supervision to Home Health Aides has the potential for unmet patient needs and possible negative patient outcomes. This has the potential to result in unmet patient needs and/or provision of improper care. This affected Patients 1, 3, 9 and 15. Examples include: Patient 1 - This [redacted] year-old patient with diagnoses of Alzheimer's Disease with dementia,	G 229	Attachment #12	

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G 229	Continued From page 34 type II diabetes mellitus and hypertension, was admitted to the agency on 08/28/08. The plan of care (POC) for the certification period from 04/25/09 to 06/23/09 contained orders for the Home Health Aide (HHA) service five (5) to seven (7) times a week for nine (9) weeks and skilled nursing orders for HHA supervision every fourteen (14) days and as needed. HHA services were provided during this period. The clinical record indicated that Registered Nurse (RN) documented HHA supervision on 05/07/09. The next HHA supervision documented by the RN was completed fifteen (15) days later on 05/22/09. The agency policy "Home Health Aide" last reviewed 12/08 states, "It is the responsibility of the CHN (Community Health Nurse) to continue the assessment of the total needs of the clients and to supervise the home health aide every 14 days as needed." Interview with the Director of Park Ridge at Home at the Manager of Quality Compliance and Safety on 07/24/09 agreed that the HHA had not been supervised every 14 days as ordered. Patient 9 - This [redacted]-year-old patient with diagnoses that include Multiple Sclerosis and urinary retention was admitted to the agency on 04/24/07. The plan of care from 06/12/09 to 08/10/09 contained orders for Home Health Aide (HHA) service four (4) to seven (7) times a week for nine (9) weeks and skilled nursing orders for HHA supervision every fourteen (14) days and as needed. HHA services were provided during this period. The clinical record indicated the Registered Nurse (RM) documented HHA supervision on 07/1/09. The next HHA supervision documented by the RN was completed fifteen (15) days later on 07/16/09.	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337267	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIDGE AT HOME LTHHCP	2300 BUFFALO ROAD BUILDING 400 ROCHESTER, NY 14624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 35 The agency policy "Home Health Aide" last reviewed 12/08 states, "It is the responsibility of the CHN (Community Health Nurse) to continue the assessment of the total needs of the clients and to supervise the home health aide every 14 days and as needed." Interview with the Director of Park Ridge at Home at the Manager of Quality Compliance and Safety on 07/27/09 provided no further information. Patient 15 - This [redacted]-year-old patient, with diagnoses that include Parkinson's, Rheumatoid Arthritis and dementia, was admitted to the agency on 11/18/08. The plan of care from 05/17/09 to 07/15/09 contained orders for Home Health Aide (HHA) service three (3) to five (5) times a week for nine (9) weeks and skilled nursing orders for HHA supervision every fourteen (14) days and as needed. HHA services were provided during this period. The clinical record indicated that the Registered Nurse (RN) performed a HHA supervision on 06/11/09. The next HHA supervision documented by the RN was completed twenty-nine (29) later on 07/01/09. The patient continued to receive HHA services Monday through Friday throughout this period. The agency policy "Home Health Aide" last reviewed 12/08, states, "It is the responsibility of the CHN (Community Health Nurse) to continue the assessment of the total needs of the clients and to supervise home health aide every 14 days and as needed." Interview with the Director of Park Ridge at Home at the Manager of Quality Compliance and Safety on 07/27/09 provided no further information.	G 229		
G 236	484.48 CLINICAL RECORDS	G 236	Attachment #13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 236	Continued From page 36 A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on clinical record review, home observations and interview with agency staff, it was determined that for six (6) of sixteen (16) clinical records reviewed, the agency did not maintain clinical records containing accurate and appropriate information. The issues involve incomplete plans of care and inaccurate documentation, which has the potential to result in the provision of improper care. The patients affected are 3, 6, 8, 11, 12 and 15. Examples are: Patient 11 - This [redacted]-year-old patient with diagnoses that include rheumatoid arthritis, type II diabetes mellitus and hypertension was admitted to the agency on 12/29/04. The plan of care (POC) and medication list for 06/06/09 to 08/04/09 did not contain information regarding a monthly infusion of Orencia the patient was receiving at her physician's office. During a home visit on 07/21/09, the patient stated she was receiving Orencia. The clinical summary, included on the POC for 06/06/09 to 08/04/09	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 236	Continued From page 37 stated, "client going for her infusion next visit at 9 am will do visit early." Upon interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09, it was acknowledged that the patient was receiving an Orencia infusion at her physician's office and the nurse failed to include this information in the clinical record. Patient 3 - This [redacted]-year-old patient with diagnoses that include diabetes mellitus type II, congestive heart failure, ulcer of the mid-foot and Vitamin B-12 deficiency was admitted to the agency on 01/30/08. This record was reviewed as an adverse event for wound infection or deterioration wound status for the period from 01/01/09 to 03/31/09. The plan of care for 01/24/09 and 03/24/09 included skilled nursing ordered for Cyanocobalamin Injection 1000 mcg/ml one (1) milliliter (ml) injection every month. The patient's record contained a nursing problem list that indicated that the monthly Vitamin B-12 injection was completed on 02/06/09, 02/13/09, 03/06/09, 03/13/09 and 03/20/09. Upon interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09, the Manager of Quality Compliance and Safety stated that the nurse provided monthly Vitamin B-12 injections. The Manager of Quality Compliance and Safety stated the process was for the nurse to check those activities completed during each home visit. The Manager of Quality Compliance and safety acknowledged the nurse checked this activity on the nursing problem list each visit although Vitamin B-12 was not administered. Patient 15 - This [redacted]-year-old patient, with	G 236		

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G 236	Continued From page 38 diagnoses that include Parkinson's, Rheumatoid Arthritis and dementia, was admitted to the agency on 11/18/08. The patient record contained documentation by the Registered Nurse (RN) on 07/14/09 that the patient's Lyrica dose was changed to 50 mg BID (twice a day). The patient record also contained a copy off supplemental order dated 07/14/09 that was not yet signed by a physician for Lyrica TID (three times daily) by mouth. Upon interview with the Director of Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/24/09, it was acknowledged that the nurse incorrectly documented Lyrica dose in her visit noted 07/14/09. The physician was contacted to confirm the patient is to take Lyrica 50 mg TID by mouth.	G 236		
G 250	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Based on review of agency policy and procedure, the Professional Advisory Committee (PAC) minutes, from March 2007 to June 2008, and interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety, the Professional Advisory Committee failed to complete quarterly record reviews. The issue being that the record review was completed by nursing alone. The lack of clinical record review involving all disciplines has the potential for the agency to not identify the provision of poor	G 250	Attachment #14	

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G 250	Continued From page 39 care. Findings are: Review of the policy (last reviewed 11/08) entitled, "Professional Advisory Committee Annual clinic Chart Review" states, "The Professional Advisory Committee (PAC) will conduct an annual Clinic Chart Review per Federal and State Regulations. 1. The Quality Manager Supervisor will randomly select one of two records to be reviewed by the PAC." Review of the PAC minutes from 06/04/09 to 06/10/08 lacked documentation of a sample of both active and closed clinical records that were reviewed by the PAC on a quarterly basis. The minutes reflected that the committee was presented a quarterly utilization report completed by the Quality Management Team. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 reported that the ongoing clinical record review that is presented to PAC, on a quarterly basis, was completed by the registered nurses that comprise the Quality Management Team. The PAC completed the annual record review per agency policy at the meeting held 12/03/09. the following disciplines were not represented at the meeting: Physical Therapy, Occupational Therapy, Speech Therapy, and Nutritionist. Record review was not completed by all the disciplines that represent the scope of the program. The Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 agreed that the record review was not being completed on a quarterly basis by all	G 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 250	Continued From page 40 disciplines that represent the scope of the program.	G 250		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure, and interview with agency staff, it was determined that for five (5) of sixteen (16) clinical records reviewed, the nurse failed to maintain an accurate medication list as outlines in the agency's policy manual. Failure to ensure complete and accurate medication reviews by the skilled nurse has the potential for unmet patient needs and the potential for negative outcomes. Patients affected are 2, 6, 8, 11 and 15. Examples include: Patient 2 - This [redacted]-year-old patient with diagnoses that include incomplete bladder emptying, coronary atherosclerosis and diabetes mellitus type II was admitted to the agency on 01/13/09. This record was reviewed as an adverse event due to an injury caused by a fall or accident at home for the time frame from 01/01/09 to 03/31/09. The Registered Nurse (RN) documented in the patient record on 01/19/09 to 03/31/09. The Registered Nurse (RN) documented in the patient record on 01/19/09 that the patient was not to take Plavix 75 mg one tablet daily by mouth. The patient went to	G 337	Attachment #15 9-01-09	

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G 337	Continued From page 41 the emergency department on 01/18/09 due to a nosebleed and had a nasal packing completed. The RN also documented that the patient received instruction to discontinue Aspirin products until seen by her physician. The clinical record lacked documentation that supplemental orders were obtained to confirm these medication instructions with the physician. On 01/22/09, the RN documented in the patient record that she contacted the otolaryngologist, treating the patients for nosebleeds, to receive verbal instructions regarding the restart of the patient's Plavix prescription. The clinical record did not contain a supplemental order to confirm these instructions with the physician. And the nurse failed to update the patient medication list to document the stop and start of Plavix as she documented in her skilled visit notes. The agency policy entitled, "Medication Administration" last reviewed 08/08 states, "On admission a medication profile will be completed for each client. This will include a complete list of all prescription and over the counter (OTC) drugs, history of allergies. All orders for oxygen will be written on the medication sheet. The medication profile will be reviewed at all revisits and updated as needed. Any new prescription of OTC drug will be added to the medication profile which automatically generates into the 485 plan of care. A supplemental care MD order will be contained when needed." Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings. Patient 6 - This [redacted]-year-old patient with	G 337		

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G 337	Continued From page 42 diagnoses that include type II diabetes mellitus, hypertension and asthma was admitted to the agency on 03/11/09. The plan of care (POC) for 05/10/09 to 07/10/09 stated, "spouse will manage Coumadin dose per MD (medical doctor) instructions." This POC for 05/10/09 to 07/10/09 inn included orders for "PT/INR (prothrombin time/international normalized ratio) drawn by ACM lab, who notified MD (medical doctor) regarding results, who notified patient/spouse regarding med changes". This POC did not include dosage, frequency and route for Coumadin. The medication list in the patient record, dated 07/22/09, did not include a current listing of Coumadin, including dosage, frequency and route. Interview with the Director of Park Ridge at Home and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings. Patient 14 - This [redacted] year-old patient, with diagnosis of multiple sclerosis, urinary tract infection, and hypertensive heart disease, was admitted to the agency on 03/28/02. the clinical record was reviewed for certification period from 06/19/09 to 08/17/09. On 08/29/09 the nurse documented, "Client seen today for bi-weekly CHN (Community Health Nurse) visit.... Client went to see PCP (Primary Care Physician) last week. Started on Advair disk BID (twice daily). CHN instructed client on how to use inhaler. Client returned to re-demonstration on how to use an inhaler." The medication list in the patient record, dated 07/22/09, did not include a current listing of Advair disk, including dosage, frequency and route. Interview with the Director of Park Ridge at Home	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 337	Continued From page 43 and the Manager of Quality Compliance and Safety on 07/27/09 confirmed these findings.	G 337		

Park Ridge at Home
Provider #33-7267
Addendum to Plan of Correction submitted August 20, 2009

G144. Attachment #1 pg. 4

Addendum: To monitor the success of the corrective action, in order to ensure that the deficient practice does not recur, The PRAH staff will implement the following action:

If the result of the audit shows an unfavorable trend with case management /coordination of service related to inconsistent or lack of ongoing communication among disciplines involved with the case, we will implement a quality improvement process. The quality improvement process may include, but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G152. Attachment #2 pg. 2

Addendum: To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will:

If the audit results reveal Professional Advisory Committee members' attendance requirement is not being met per policy 0004A (Professional Advisory Committee), the individual member will be contacted and the importance of their commitment reinforced. If continued non-attendance becomes an issue, the individual will be replaced on the committee.

G158. Attachment #3 pg. 2

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the result of the audit shows an unfavorable trend to indicate that the clients are not receiving care as directed by the plan of care, we will implement a quality improvement process. The quality improvement process may include not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G159. Attachment #4 pg. 3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the result of the audit show an unfavorable trend indicating the plan of care was not sufficient to meet the scope of clients needs, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G164. Attachment#5 pg. 3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the results of the audit show an unfavorable trend indicating that ongoing and timely communication with the MD based on client changes is not occurring, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G166. Attachment#6 pg.3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the results of the audit show an unfavorable trend to indicate that the MD has not been notified with changes in the plan of care, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G170. Attachment#7 pg. 3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the results of the audit show an unfavorable trend indicating the clinician is not providing skilled nursing services in accordance with the plan of care, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G172. Attachment#8 pg. 3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the results of the audit show an unfavorable trend that the clinician is not re-evaluating the clients nursing needs, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G176. Attachment#9 pg. 3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the result of the audit show an unfavorable trend indicating the clinician has not prepared clinical progress notes, coordinated services and informed the MD of changes in the client's condition, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G177. Attachment#10 pg. 2

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the results of the audit show an unfavorable trend indicating clinical staff has not counseled client/PCG to meet nursing and other needs related to wound care, urinary catheterization and medication instruction, we will implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G224. Attachment#11 pg. 2

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will:

If the results of the audit show an unfavorable trend indicating that the aide is not following the comprehensive written care plan, the responsible clinician will be notified and will provide re-education ~~of~~ to the home health aide.

G229. Attachment#12 pg. 2

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will:

If the results of the audit show an unfavorable trend that indicates clients with aide service are not supervised every 14 days, the responsible clinician will be notified immediately and 1:1 re-education will occur. We will also implement a quality improvement process. The quality improvement process may include but not limited to: clinical staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G236. Attachment#13 pg. 2

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the result of the audit show an unfavorable trend indicating the clinical record lacks complete documentation with medication documentation, we will implement a quality improvement process. The quality improvement process may include but not limited to: staff/team education, joint home visits, and record review(s) with responsible clinical staff.

G250. Attachment#14 pg. 2

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the result of the audit shows that the Utilization Review Committee meeting is not attended per policy 0003A(Utilization Review Committee) the individual member will be contacted and the importance of their commitment reinforced. If continued non-attendance becomes an issue, the individual will be replaced on the committee.

G337. Attachment#15 pg. 3

Addendum: To monitor the success of the corrective action, in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

If the results of the audit show an unfavorable trend to indicate the Community Health Nurse is not maintaining an accurate and complete medication profile as ordered with the plan of care, we will implement a quality improvement process. The quality improvement process may include but not limited to: nursing/team education, joint home visits, and record review(s) with responsible clinical staff.

Unity Health System

Margaret Jordan
Home Care Director
New York State Department of Health
335 East Main Street
Rochester, New York 14604-2127

August 20, 2009

RE: Park Ridge at Home
Provider # 33-7267
Survey Date: July 28, 2009

Dear Ms. Jordan:

Enclosed please find our completed Plan of Correction in response to the Statement of Deficiencies report from the Article 36, Medicare/Medicaid partial extended recertification survey ending July 28, 2009.

In the spirit of quality improvement and excellent patient care, we have developed our plan of correction to address the issues identified in the Statement of Deficiencies, with the ultimate goal being to further enhance the care and services we deliver to our patients. We continually aspire to seek additional improvements toward this ongoing goal.

Please do not hesitate to contact me should additional information be desired. Thank you.

Sincerely,

Jane Shukitis
Vice President, Home and Community Based Services
Unity Health System

2300 Buffalo Road Building 400 | Rochester, New York 14624 | Phone: 585.368.6342 | Fax: 585.368.6395
Affiliate of the University of Rochester School of Medicine and Dentistry

484.14(g) **Coordination of Patient Services**

The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

Debra Lyda, RN, BSN – Director - Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the client affected by the deficiency is as follows:

1) PRAH currently has a policy (0010A) addressing client care conferences. In order to improve the comprehensive multi-disciplinary conferences efficiency and effectiveness, and, thus, be able to address the deficiencies identified, PRAH will review and revise the above-mentioned policy.

   In addition, PRAH will review and/or revise the policies listed below for improved communication and effectiveness at client care conferences, while continuing to define the expectations of each discipline:
   - 0017A Nursing
   - 0018A Nutrition
   - 0019A Physical Therapy
   - 0020A Occupational Therapy
   - 0021A Speech/Language Therapy
   - 0022A Medical Social Work
   - 0024A Respiratory Therapy Services

   PRAH will write a comprehensive policy and procedure for Telehealth Monitoring to be used in the coordination of care for the client in need of daily monitoring. These policies will be reviewed with all clinical staff.

2) The PRAH clinical supervisor will meet with each CHN to review the effectiveness and coordination of services with the clients indicated in the deficiency: Clients 5, 6, 7, 8 ,9, 10, 13, 15, and 16. One on one discussions between the clinician and supervisor will include, but not be limited to, specific case management/coordination of service issues, communication with the other disciplines involved in the case, and follow-up actions for each patient noted above. Particular emphasis, as it pertains to the individual case, will be placed on the following:
   - Coordination regarding Personal Emergency Response System units
   - Telehealth monitoring
   - Social day care needs
   - Skin assessment, reporting of changes
   - Aide service
   - Plan of care changes

3) Specifically, the review for the following clients will include:

Patient #5: Review of telehealth policy upon completion.

Patient #6: Review of coordination of care and reporting for Home Health Aide, Personal Emergency Response system, review of Physician contact policy and documentation in Clinical Records. Review of medication policy as it pertains to Coumadin with appropriate coordination of care between lab, MD, client, and CHN.

Patient #7: Review of coordination of care and plan of care changes in regards to respite care and frequency/duration of aide.

Patient #8: Review of documentation in clinical records specifically in regards to telehealth monitoring and skin assessment. Review of Policy regarding physician contact.

Patient #9: Review of coordination of care as it relates to reporting for Home Health Aides. Review and reinforce the plan of care with HHA, reeducation and reinforce the responsibility of the HHA to alert the CHN with patient changes in condition, especially as it relates to skin assessments.

Patient #10: Review of policies regarding: Documentation in Clinical Records, Assessment and Documentation of Pain, and Physician Contact.

Patient #13: Review of coordination of care and reporting for Home Health Aide. Specific review of CHN responsibility to reinforce and review the plan of care with HHA, reeducate on HHA supervision to review POC in home, and reinforce the responsibility to alert the CHN with patient complaints.

Patient #15: Review of coordination of care as it relates to social day care , in particular the communication between disciplines to assess client needs.

Patient #16: Review of coordination of care, responsibility of CHN to review plan of care with HHA to assure the POC is being followed. Review of policy regarding physician contact and MD orders.

4) A chart audit following each of the above supervisory visits will be conducted to ensure appropriate documentation standards are met, and case management and/or follow-up coordination of services are completed, and the MD is notified accordingly.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case managing CHN will be reviewed by a PRAH supervisor to assess whether good coordination of patient services is evident in the documentation.

2) If a less than satisfactory trend is noted, the identified CHN will have the same level of education and remediation as described under corrective action #2 above, including a supervisory home visit.

The systemic changes that will be implemented to ensure that the deficiencies do not recur are as follows:

1) Three interdisciplinary teams will be formed. All PRAH clinical staff will be assigned to a team. Teams will be organized around three groups of case management CHNs within a geographical proximity, in order to provide a cohesive, interdisciplinary team that cares for the same group of clients. This cohesiveness and proximity will foster improved communication and coordination of client services by nature of its arrangement.

2) Each team will meet once a month for case review, the format of which will be included in the revision of Policy 0010A (Client Care Conferences). The case review of each case will focus on coordination of client services, revisions to the plan of care, progress and changes to date, and long/short-term goals. A PRAH supervisor will be assigned to each team to facilitate discussion, assist in coordination of services, and to foster communication and planning between disciplines. Documentation of issues discussed at the team meetings will be entered into MISYS clinical notes by a designed clinical staff member. This documentation serves as a point of reference for improved coordination of services, coordination of care between disciplines and for the continuity of care that is essential as a 24 hour operation.

3) Supervisory staff will meet one on one with each member of their discipline's team a minimum of once a month to review client plan of care and review the effectiveness of coordination of patient services. Documentation of the one on one meetings will be maintained by supervisory staff.

4) 100% of the PRAH clinical staff will attend an educational in-service to review the policies 0010A (Patient Care Conference), 0025A (Home Health Aide), 0049D (Physician Contact), 0079A (Assessment and Documentation of Pain), 0080A (Documentation in the Client Record) and the Telehealth Policy and Procedure. A copy of the policies will be distributed to the clinical staff. This in-service will be repeated annually.

5) On an annual basis, all clinical staff will have a supervisory visit with a subsequent chart audit of that visit completed by a PRAH supervisor. The focus of this review will be to assess each clinician's competency regarding coordination of patient services and appropriate documentation of that coordination. Any identified problems will be addressed with the clinician on an individualized basis.

6) Records from HealthCall, the Personal Emergency Response Unity, will be obtained monthly to assure coordination of services with the clients by comparing documentation in MISYS to HealthCall records.

7) Records from the Social Day Cares will be obtained on a monthly basis to assure coordination of services, to review client attendance, and compliance with MD orders.

To monitor the success of the corrective action, in order to ensure that the deficient practice does not recur, PRAH will implement the following action:

1) PRAH supervisors will review a minimum of 10% of the records of all clients discussed in the team meetings that are identified as high risk, to include but not be limited to recently hospitalized clients, clients with complaints regarding coordination of services, telehealth clients, non-compliant clients, those with high-risk diagnoses (e.g. wounds, diabetes, renal failure). This review will be completed monthly to ensure the appropriateness of documentation and coordination of client services.

The completion date will be 10/31/09.

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484.16 – Group of Professional Personnel

A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines.

Debra Lyda RN, BSN– Director – Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

Issue #1- The Governing Body failed to ensure that the Park Ridge at Home Professional Advisory Committee (PAC) had adequate representation among its membership. Review of the membership for the PAC of years 2008 and 2009 lacked representation of speech language pathology services, occupational therapy, and respiratory therapy on the committee.

- PRAH will recommend qualified representatives for speech language pathology services, occupational therapy, and respiratory therapy to the Governing Body for appointment to the Park Ridge at Home, PAC. The Governing Board of PRAH shall approve the recommendation based on qualifications of the recommended representatives.

Issue #2- Review of the PAC minutes from 06/04/08 – 06/10/09 indicated that the medical social worker was not present for the PAC 06/04/08 and 9/03/08. Review of the PAC minutes from 06/04/08 to 06/10/09 indicated that the nutritionist was not present for the PAC meeting on 06/04/08, 09/03/08, 12/03/08, 03/11/09, 06/10/09.

- PRAH will review/revise policy 0004A Professional Advisory Committee with reference to attendance requirements of members.

- PRAH will revise policy 0004A – Professional Advisory Committee to address back up plan for those members who are unable to attend a Professional Advisory Committee meeting.

- PRAH will review with all PAC members the attendance responsibility per policy 0004A Professional Advisory Committee and back up plan.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

All patients would be affected by this deficiency. Corrective action stated above.

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The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

- PAC membership and meeting attendance will be reviewed quarterly, (4) times annually to ensure compliance to proper representation on committee and compliance with attendance requirements.

- If any issues are identified, membership changes will be facilitated per policy 0004A- Professional Advisory Committee.

- Annually PRAH will review with all PAC members the attendance responsibility per policy 0004A- Professional Advisory Committee and back up plan.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will:

- Audit PAC membership and meeting attendance quarterly, (4) times annually as part of the Park Ridge at Home quality improvement plan.

Completion date will be 10/31/09.

484.18 Acceptance of patients, POC and Med supervision.

Care follows a written plan of care established and periodically reviewed by doctor of medicine, osteopathy, or podiatric medicine.

Debra Lyda, RN BSN– Director– Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 1, 7, 8,9,15 and 16. The PRAH supervisor will discuss the specific standards not met as evidenced by clients not receiving care as directed by their plan of care that was established by MD and review what actions should have transpired to ensure a complete and accurate plan of care was in place. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

The one-on-one clinician counseling and chart review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

Client # 1: Review assessment and clinical documentation of the Endocrine system to include monitoring of BG when caregiver assumes this role, assessment of BG at each visit, notification to MD when BG is outside of ordered parameter, and HHA supervision every 14 days.

Client # 7: Review frequency and duration of aide service as ordered in plan of care, verbal order for disciplines in plan of care.

Client #8: Review of blood glucose ranges and documentation, review of frequency and dose of sliding scale insulin as administered by client, and nutrition education for appropriate diabetic diet and assessment of food choices.

Client # 9: Review assessment and documentation of Urinary system with each visit as ordered by plan of care.

Client # 15: Review frequency of HHA supervision.

Client # 16: Review following the plan of care as ordered for wound care.

2) The PRAH supervisor will review each client's record and compare the documentation and observations from the above noted supervisory home visit with the current plan of care. These observations will be reviewed with the clinician and any inaccuracies

found in plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify clients are receiving care as directed by their plan of care established by MD.

2) If a record is found with an incomplete plan of care, these observations will be reviewed with the clinician and the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described above, including an in-home supervisory visit and follow-up record audit and review.

3) Any revisions or additions to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow - up record audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review policies 0049A (Medical Policies, Standard Medical Regimes and Standing Orders), 0060E (Clinical Parameters), 0080A (Documentation in Clinical Record), 0025A (HHA Supervision), 0049E (Medication Administration).The policies will be distributed to all clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of the client records for the assigned staff members to ensure completeness of orders and to ensure plan of care is followed as ordered.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review tool that will be used will include an indicator to measure compliance that clients receive care as directed by their plan of care. New indicators will be added to assess complete documentation of the endocrine and urinary systems.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

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Attachment #4

484.18 (a) -Plan of Care

The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

Debra Lyda, RN BSN– Director - Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) PRAH will develop a Policy and Procedure for Telehealth Monitoring of Clients.

2) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 1, 6,7,8,10,11 and 13. The PRAH supervisor will discuss the specific standards not met as evidenced by staff not ensuring that the plan of care was of sufficient scope to meet the client's needs and review what actions should have transpired to ensure a complete and accurate plan of care was in place. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

The one-on-one clinician counseling and record review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

Client: # 1: Review accurate diet per plan of care, ensure accuracy of frequency and duration of respite hours, accurate assessment and documentation in endocrine system review, communication with Social Day Care, aide supervision every 14 days and monitoring aide following the care plan.

Client# 6: Review medication profile for accuracy, when a medication has been discontinued per plan of care ensure that the problem as been discontinued also.

Client # 7: Review frequency and duration of aide service per plan of care, verbal order or disciplines involved in the plan of care.

Client # 8: Review of frequency and dose of sliding scale insulin as administered per plan of care, telehealth monitoring review with client with each visit.

Client # 10: Review plan of care for accuracy (PERS), follow frequency and duration of disciplines per plan of care, accurate assessment and documentation of chronic pain, GI system, diet per plan of care.

Client # 11: Review accuracy of current medication profile that client takes per plan of care to include medication that administered at hospital.

Client # 13: Review complete wound assessment every visit, notification to MD for changes related to wound, documentation of teaching primary caregiver with wound care, orders to prefill mediset, changes with medication needs verbal order from MD, notification to CHN by aide with significant changes related to care plan.

3) The PRAH supervisor will review each client's record and compare the documentation and observations from the above noted supervisory home visit with the current plan of care. These observations will be reviewed with the clinician and any inaccuracies found in the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify that the plan of care is of sufficient scope to meet the client's needs.

2) If a record is found with an incomplete plan of care, these observations will be reviewed with the clinician and the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow-up record audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review policies 0049A (Medical Policies, Standard Medical Regimes and Standing Orders), 0080A (Documentation in the Clinical Record), 0049E (Medication Administration), 0025A (HHA Supervision), 0049D (Physician Contact), 0079A (Assessment and Documentation of Pain), 0060F (Assessment and Reporting of Wounds), 0071A (Respite Care) and a new Telehealth Policy. A copy of the policies will be distributed to the clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of the patient records for the assigned staff members, to ensure plan of care was of sufficient scope to meet client needs.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review tool that will be used will include an indicator to measure compliance in following the ordered plan of care. New indicators will be added to measure compliance with complete documentation of endocrine system and medication profile for accuracy.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.18(b)–Periodic Review of Plan of Care

Agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care.

Debra Lyda, RN, BSN– Director – Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 1, 2, 8, and 13. The PRAH supervisor will discuss the standard not met as evidenced by clinical records lacking documentation that the MD was contacted by staff when the client's condition changed and review what actions should have transpired to ensure a complete and accurate plan of care was in place. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

The one-on-one clinician counseling and record review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

Client # 1: review assessment and clinical documentation of the Endocrine system to include monitoring of BG when caregiver assumes the role, notification to MD when BG is outside ordered parameters.

Client # 2: review when a medication is on hold due to circumstances that warrant that, there will be contact with the MD to make aware and orders per the plan of care.

Client # 8: when changes are noted with skin integrity, notification of MD is required to update and to change the plan of care if appropriate.

Client # 13: assess wounds every visit, measure every week, confirm wound care orders and notify MD with any changes.

To identify other patients having the same potential, and the corrective action to be taken as follows:

1) 20% of the medical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify that clinical records have documentation that the MD was contacted by staff when the client's condition changes.

2) If a record is found with an incomplete plan of care, these observations will be reviewed with the clinician and the plan of care will be corrected.

3) Any revisions or updates to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow-up record audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review policies 0049A (Medical Policies, Standard Medical Regimes and Standing Orders), 0080A (Documentation in the Clinical Record), 0049D (Physician Contact), 0060F (Assessment and Reporting of Wounds), 0060E (Clinical Parameters) and 0049E (Medication Administration). A copy of the policies will be distributed to the clinical staff. This in-service will be repeatedly annually.

2) On an ongoing basis, the PRAH supervisor will audit 10% of records of assigned staff members to ensure completeness of assessments and follow up with completed MD orders as related to changes in client plan of care.

3) Three interdisciplinary teams will be formed. All PRAH clinical staff will be assigned to a team. Teams will be organized around three groups of case management CHNs within a geographical proximity, in order to provide a cohesive, interdisciplinary team that cares for the same group of clients. This cohesiveness and proximity will foster improved communication and coordination of client services by nature of its arrangement.

4). Each team will meet once a month for care review, the format of which will be included in the revision of Policy 0010A (Client Care Conferences). The review of each case will focus on coordination of client services, revisions to the plan of care, progress and changes to date, long /short term goals. A PRAH supervisor will be assigned to each team to facilitate discussion, assist in coordination of services, and to foster communication and planning between disciplines. Documentation of issues discussed at the team meetings will be entered electronically by a designated clinical staff member. This documentation serves as a point of reference for improved coordination of services, coordination of care between disciplines and for the continuity of care that is essential as a 24 hour operation.

5) Supervisory staff will meet one on one with each member of their discipline's team a minimum of monthly to review client plan of care and review the effectiveness of coordination of client services. Documentation of the one on one meetings will be maintained by supervisory staff.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include an indicator to measure compliance of ongoing and timely communication with the MD based on client changes.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.18(c) – Conformance with Physician Orders

Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.

Debra Lyda, RN, BSN– Director - Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 2, 12, 13 and 16. The PRAH supervisor will discuss the standard not being met as evidenced by clinical records lacked evidence that orders were obtained for changes in the plan of care and review what actions should have transpired to ensure a complete and accurate plan of care was in place. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

The one-on-one clinician counseling and record review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

Client #2: Review the process when a medication is put on hold there needs to be a supplemental order signed by the MD and the medication needs to be held and/or discontinued in the medication profile.

Client #12: Review the process for obtaining a supplemental order signed by the MD for a verbal order to have a discipline (Respiratory) involved with the plan of care.

Client # 13: Review the process when a medication dose is changed and/or held there needs to be a supplemental order signed by the MD and the medication needs to be held and/or discontinued in the medication profile.

Client # 16: Review the process when a verbal order is obtained that the order needs to be signed by the MD and part of the clinical record. This issue was related to calling the MD for verbal order for wound culture, but no signed order in record.

2) The PRAH supervisor will review each client's chart and compare the documentation and observations from the home visit with the current plan of care. This will be reviewed with the clinician. Any concerns noted in the assessment or lack of documentation in regards to obtaining MD orders for changes in the plan of care will be reviewed with the clinician, with corrective instruction provided as indicated. If needed, the plan of care will be updated and verbal orders will be sent to the MD.

To identify other patients having the same potential, and the corrective action to be taken as follows:

1) 20% of the records for each case managing CHN will be audited to ensure clinical records have evidence that orders are obtained for changes in the plan of care.

2) If a record is found with an incomplete plan of care, these observations will be reviewed with the clinician and the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the physician. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1above under corrective action, including an in-home supervisory visit and follow-up record audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review policies 0049E (Medication Administration), 0049D (Physician Contact), 0049A (Medical Policies, Standard Medical Regimes and Standing Orders), and 0080A (Documentation in the Clinical Record). A copy of the policies will be distributed to the clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, the PRAH supervisors will audit 10% of charts of assigned staff members to ensure completeness of assessments and follow up with completed MD orders as related to changes in patient plan of care.

3) Three interdisciplinary teams will be formed. All PRAH clinical staff will be assigned to a team. Teams will be organized around three groups of case management CHNs within a geographical proximity, in order to provide a cohesive, interdisciplinary team that cares for the same group of clients. This cohesiveness and proximity will foster improved communication and coordination of client services by nature of its arrangement.

4). Each team will meet once a month for care review, the format of which will be included in the revision of Policy 0010A (Client Care Conferences). The review of each case will focus on coordination of client services, revisions to the plan of care, progress and changes to date, long /short term goals. A PRAH supervisor will be assigned to each team to facilitate discussion, assist in coordination of services, and to foster communication and planning between disciplines. Documentation of issues discussed at the team meetings will be entered electronically by a designated clinical staff member. This documentation serves as a point of reference for improved coordination of services, coordination of care between disciplines and for the continuity of care that is essential as a 24 hour operation.

5) Supervisory staff will meet one on one with each member of their discipline's team a minimum of monthly to review client plan of care and review the effectiveness of coordination of client services. Documentation of the one on one meetings will be maintained by supervisory staff.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include an indicator to measure compliance that the medical record has MD orders for all changes in the plan of care.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.30 Skilled Nursing Services

The HHA furnishes skilled nursing services in accordance with the plan of care and as reference under G158, which is **484.18 Acceptance Of Patients, POC, Med Super.**

Debra Lyda, RN BSN– Director– Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients, 1, 8, 9, 13, 15, and 16. The PRAH supervisor will discuss the specific Plan of Care issues identified in these cases and review what actions should have transpired to ensure that the patient received care as directed by the plan of care as established by the MD. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

2) The one-on-one clinician counseling and chart review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

   Client #1: review of documentation in the clinical record, related to the problem of clinician assessment of range of Blood Glucoses, of when to notify MD of BGs not within parameters, and complete assessment of BGs as monitored by family.

   Client #8: review of documentation in the clinical record, related to the problem of clinician assessment of range of BGs, review of complete orders for insulin sliding scale frequency consistent with BG testing, and review of nutrition education for appropriate diabetic diet/assessment of food choices.

   Client #9: review documentation in the clinical record, related to the problem of incomplete Genitourinary assessments done by clinician, and review of complete assessment with documentation.

   Client #13: review assessment and reporting of wounds, and when to notify MD of changes in wound status and /or client condition.

   Client #15: review process of supervision of Home Health Aide every 14 days and as needed, and complete documentation in the clinical record of supervision.

   Client #16: review assessment of wounds, to include the wound dressing type, frequency of change and who is responsible for the dressing change, and documentation.

The PRAH supervisor will review each client's record and compare the documentation and observations as described in #1 and #2 above under corrective action, including compliance of clinician to provide skilled nursing services in accordance with the plan of care. These observations will be reviewed with the clinician and any inaccuracies found in the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify that the clinician has provided skilled nursing services in accordance with the plan of care.

2) These observations will be reviewed with the clinician and the plan of care will be corrected if a record is found where the clinician has failed to provide skilled nursing services in accordance with the plan of care.

3) Any revisions or updates to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 and #2 above, including an in-home supervisory visit and follow-up chart audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review the policies 0025A (Home Health Aide), 0049A (Medical Policies-Standards Medical Regimens), 0049C (Blood Glucose Monitoring), 0060E (Clinical Parameters), 0060F (Assessment and Reporting of Wounds), and 0080A (Documentation in Clinical Record). Copies of the policies will be distributed to clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of the patient records for the assigned staff members to ensure that clinicians are providing skilled nursing services in accordance with the plan of care.

3) These observations will be reviewed with the clinician and the plan of care will be corrected if a record is found where the clinician has failed to provide skilled nursing services in accordance with the plan of care.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include indicators to measure compliance that clinicians provide skilled nursing services in accordance with the plan of care.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.30(a) Duties Of The Registered Nurse

The registered nurse regularly re-evaluates the patients nursing needs.

Debra Lyda RN BSN– Director – Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) PRAH will develop Policy & Procedure for Telehealth Monitoring of Clients.

2) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 1, 5, 6, 8, 9, 10, 12, 13, and 16. The PRAH supervisor will discuss the specific plan of care issues identified in these cases and review clinician's assessment and reassessment of patient's nursing needs. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

3) The one-on-one clinician counseling and chart review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific patient issues:

   Client #1: review of blood glucose monitoring, related to reevaluation of blood glucose ranges, and reevaluation of assessment of genitourinary status.

   Client #5: review reevaluation of patient's needs, related to Telehealth.

   Client #6: review assessment of skin, reevaluation of coagulation therapy, and documentation in clinical record, related to accuracy of medications in the clinical record.

   Client #8: review of Home Health Aide, related to duties/application of dressings to intact skin, blood glucose monitoring, related to reevaluation of sliding scale insulin, and reevaluation of wounds.

   Client #9: review reevaluation of the Genitourinary status of client, and documentation in clinical record, related to interdisciplinary communication of client status.

   Client #10: review reevaluation medication administration, related to Lovenox.

   Client #12: review blood glucose monitoring, related to reevaluation of BG ranges.

Client #13: review reevaluation of wounds, and reevaluation of medication administration, related to coumadin therapy.

Client #16: review reevaluation of wounds, timing of dressing changes to reflect orders in plan of care to meet patient's nursing needs.

The PRAH supervisor will review each client's record and compare the documentation and observations as described in #2 and #3 above under corrective action, including re-evaluation by the clinician of client's nursing needs. These observations will be reviewed with the clinician and any inaccuracies found in the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of medical records for each case-managing CHN will be reviewed by a PRAH supervisor, to verify that the clinician regularly reevaluates the patient's nursing needs. This will include a review of the assessment, management, and reevaluation of pain, skin and wound care, lab work, blood glucose, and telehealth.

2) These observations will be reviewed with the clinician, and the plan of care will be corrected if a record is found where the clinician failed to regularly reevaluate the patient's nursing needs.

3) Any revisions or updates to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #2 and #3 above, including an in home supervisory visit and follow-up chart audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur, is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review the policies 0025A (Home Health Aide), 0049A (Medical Policies-Standards Medical Regimens), 0049C (Blood Glucose Monitoring), 0049E (Medication Administration), 0060F (Assessment and Reporting of Wounds), 0079A (Assessment and Documentation of Pain), 0080A (Documentation in Clinical Record), and Telehealth. Copies of the policies will be distributed to clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, the PRAH supervisors will audit 10% of patient records for assigned staff members to ensure that clinicians regularly reevaluate patient's nursing needs.

3) These observations will be reviewed with the clinician and the plan of care will be corrected if a record is found where the clinician has failed to regularly re-evaluate the patients nursing needs.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will:

1) Integrate new indicators into the PRAH Utilization Review Tool to track and report compliance with new policy standards for assessment and documentation of Telehealth.

2) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

3) The Utilization Review Tool that will be used will include indicators to measure compliance that clinician has regularly re-evaluated the patients nursing needs.

4) The PRAH Clinical Supervisors will continue to supervise and conference with the clinician on an ongoing basis, meeting a minimum of once monthly, to ensure compliance with practice standards when evaluating patient needs.

5) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.30(a) Duties of the Registered Nurse

The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.

Debra Lyda, RN BSN– Director– Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) PRAH will develop Policy & Procedure for Telehealth Monitoring of clients.

2) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 13, 15, and 16. The PRAH supervisor will discuss the specific plan of care issues identified in these cases and review what actions should have transpired to ensure that the clinician prepared clinical/progress notes, coordinated services, and informed the MD and other personnel of changes in the client's condition and needs. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

   The one-on-one clinician counseling and chart review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific patient issues:

   Client #1: review the process of contact with Social Worker and Social Day Care to ensure communication of patient status and changes. Review process of informing MD with BG outside of normal parameters.

   Client #2: review the process of informing MD of changes in vital signs outside of normal parameter/confirm anticoagulant medication, and need for further follow up if MD does not respond.

   Client #3: review the process of documenting B12 injections/use of Problem Charting.

   Client #5: review the process of documenting and coordinating Telehealth.

   Client #6: review the process of documenting and follow-up on lab work done for patient, and informing MD of vital signs outside of normal parameters.

Client #7: review the process of informing MD of vital signs outside of normal parameters, and informing SW of changes in client status.

Client #8: review the process of informing MD of changes in patient's condition, e.g. change in wound/confirm treatment and medications, and coordinating services with Nutrition and PT.

Client #9: review process of documenting GU assessment, follow up with MD when warranted, and coordinating services with PT.

Client #10: review process of coordinating care with SW, PT, and informing MD of changes in patient's condition-increased pain.

Client #11: review process of documenting HHA issues in clinical record, and follow up with Primary Caregiver.

Client #13: review assessment of wound and informing MD of increased drainage and change in wound status.

Client #15: review process of coordinating care with OT/PT, and follow up on their recommendations, follow up on patient's interest in going to SDC, and documentation of HHA supervisions in the clinical record.

Client #16: review process of informing MD of changes in wound, and follow up with MD in timely fashion, documentation of findings related to edema, and follow up of wound culture results.

The PRAH supervisor will review each client's record and compare the documentation and observations from the above noted supervisory home visit with the current plan of care. These observations will be reviewed with the clinician and any inaccuracies found in the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify that the clinician has prepared clinical and progress notes, coordinated services and informed the MD and other personnel of changes in the patient's condition and needs.

2) These observations will be reviewed with the clinician and the plan of care will be corrected if a record is found where the clinician has failed to prepare clinical

and progress notes, coordinate services and inform the MD and other personnel of changes in the patient's condition and needs.

3) Any revisions or updates to the Plan of Care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #2 above of corrective action, including an in-home supervisory visit and follow-up chart audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review the policies 0010A (Client Care Conferences), 0025A (Home Health Aide), 0049A (Medical Policies, Standard Medical Regimes and Standing Orders), 0049D (Physician Contact), 0049E (Medication Administration), 0060E (Clinical Parameters), 0060F (Assessment and Reporting of Wounds), 0080A (Documentation in the Clinical Record), and Telehealth. Policies will be distributed to clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of the patient records for the assigned staff members to ensure that clinician has prepared clinical and progress notes, coordinated services and informed the MD and other personnel of changes in the client's condition and needs.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include indicators to measure compliance that clinician has prepared clinical and progress notes, coordinated services and informed the MD and other personnel of changes in the client's condition and needs.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

1) 20% of the medical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify that the clinician has counseled and/or observed the patient/PCG skills to meet nursing and other related needs, related to wound care, urinary catheterization and medication instruction.

2) These observations will be reviewed with the clinician and the Plan of Care will be corrected if a record is found where the clinician has failed to counsel patient/PCG to meet nursing and other needs related to wound care, urinary catheterization and medication instruction.

3) Any revisions or updates to the Plan of Care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow-up chart audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service to review the policies 0049 A (Medical Policies, Standard Medical Regimes and Standing Orders), 0049E (Medication Administration), 0059A (Infection Control-Client/Family Education), 0060F (Assessment and Reporting of Wounds), and 0080A (Documentation in the Clinical Record). Copies of the policies will be distributed to the clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of the patient records for the assigned staff members to ensure that clinician has counseled patient/PCG to meet nursing and other related needs related to wound care, urinary catheterization and medication instruction.

3) These observations will be reviewed with the clinician and the Plan of Care will be corrected if a record is found where the clinician has not counseled and or observed the patient/PCG to meet nursing and other needs related to wound care, urinary catheterization and medication instruction are met.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include an indicator to measure compliance for clinician counseling of the client/ PCG as it relates to meeting nursing and other related needs.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.36(c) (1)-Assignment and duties of Home Health Aide

Written patient care instructions for the home health aide (HHA) must be prepared by the registered nurse or other professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.

Debra Lyda, RN, BSN– Director of Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet with meet one-on-one with the clinicians involved with the clients identified in this deficiency - clients 3,4,6,8, and 14. The supervisor will discuss the CHN role when supervising home health aides to include comparison of aide activity record documentation with the written care plan. This will include reviewing aide activity record documentation for accuracy compared to the written care plan with the HHA. The PRAH supervisor will complete in-home supervisory visit with each clinician to assess performance. Any revisions or updates to the plan of care will be sent to the MD.

The one-on-one clinician counseling and record review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

Client # 3: Review of clinical records lacked evidence that the clinician had completed comprehensive written instructions for the home health aide. Aide documented weighing client weekly. There was not an order in the plan if care.

Client # 4: Review of the clinical records lacked evidence that the clinician had completed comprehensive written instructions for the home health aide. Aide documented medication reminders. There was not an order in the plan of care.

Client # 6: Review of the clinical records lacked evidence that the clinician had completed comprehensive written instructions for the home health aide. Aide documented medication reminders and remind to wear health call button. There was not an order in the plan of care.

Client #8: Review of clinical records lacked evidence that the clinician had completed comprehensive written instructions for the home health aide. Aide documented assist with telehealth 3xweek. There was not an order in the plan of care.

Client # 14: Review of the clinical record lacked evidence that the clinician had completed comprehensive written instructions for the home health aide. Aide documented assisting client with home exercise program. There was not an order in the plan of care.

2) The PRAH supervisor will review each client's chart with aide service and compare the documentation and observations from above noted supervisory visit with current plan of care. These observations will be reviewed with the clinician and any inaccuracies found in the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case managing CHN with clients receiving aide service will be reviewed by PRAH supervisor to verify there are comprehensive written instructions for home health aide to follow and are part of the plan of care.

2) If a record is found with an incomplete plan of care, these observations will be reviewed with the clinician and the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described above, including an in home supervisory visit and follow up chart audit and review.

3) Any revisions or additions to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow-up record audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100% of PRAH clinical staff will attend an educational in-service to review policy 0025A (Home Health Aide). A copy of the policy will be distributed to the clinical staff. This in-service will be repeated annually.

2) On an ongoing basis the PRAH supervisor will audit 10% of the client records with aide service to ensure that the home health aide is following the written comprehensive care plan as part of the plan of care.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review tool that will be used will include an indicator to measure compliance with aide documentation as compared to the written care plan.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

484.36(d)(2)- Supervision
The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on site visit to the patient's home no less frequently than every 2 weeks.

Debra Lyda, RN BSN– Director-Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients: 1, 3, 9, and 15. The PRAH supervisor will discuss the standard not met as evidenced by clinical records lacking home health aide supervisory visits conducted every 14 days and review what actions should have transpired to ensure a complete and accurate plan of care was in place.

The one-on-one clinician counseling and record review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific client issues:

Client # 1: Review onsite visit to the client's home occurs every 14 days. The clinical record indicated home health aide supervision was completed on day 15 for the period reviewed.

Client # 3: Review onsite visit to the client's home occurs every 14 days. The Clinical record indicated home health aide supervision was completed on day 15 for the period reviewed.

Client # 9: Review onsite visit to the client's home occurs every 14 days. The clinical record indicated home health aide supervision was completed on day 15 for the period reviewed.

Client # 15: Review onsite visit to the client's home occurs every 14 days. The clinical record indicated home health aide supervision was completed on day 29 for the period reviewed.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

1) 20% of the medical records for each case managing CHN with aide service will be reviewed by PRAH supervisor to ensure that clinical records document that home health aide supervisory visits are conducted every 14 days.

2) If a clinical medical record is found wherein the aide supervision was not conducted every 14 days, the supervisor will review with the case managing CHN the policy 0025D (Clinical Supervision of Home Health Aide) and the importance of adhering to this policy.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur are as follows:

1) 100 % of PRAH clinical staff will attend an educational in-service to review policy 0025D (Clinical Supervision of Home Health Aide). A copy of the policy will be distributed to the clinical staff. This in-service will be repeated annually.

2) 100% of PRAH CHN's will be required to schedule aide supervisory visits into the client's electronic medical record utilizing the patient scheduling module monthly. This will prevent missed visits due to scheduling oversights.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will:

1) The Utilization Review Committee will audit records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include an indicator to measure compliance for home health aide supervisory visits every 14 days.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09.

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484.48 Clinical Record

A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician, drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

Debra Lyda RN, BSN – Director – Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be completed for the clients' affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients 3,6,8,11,12 and 15. The PRAH supervisor will discuss the specific documentation issues identified in these cases, and review what actions should have transpired to ensure a complete and accurate clinical record. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance.

The one-on-one clinician counseling and chart review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific patient issues:

Client #3: Review of problem charting related to Vitamin B12 injection administration.

Client #6: Review of complete orders for coumadin including dose and frequency.

Client #8: Review of complete orders for insulin sliding scale frequency consistent with blood glucose testing frequency, and antibiotic ointment included on the medication record.

Client #11: Review of complete medication record including any medications administered at the MD office.

Client #12: Review of complete orders for oxygen dose.

Client #15: Review of consistent medication dose between the medication record and clinical documentation.

G236 cont'd

2) The PRAH supervisor will review each client's clinical record and compare the documentation and observations from the above noted supervisory home visit with the current clinical record including medication review. This review will be shared with the clinician and any inaccuracies found will be corrected.

3) Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential, and the corrective action to be taken as follows:

1) 20% of the clinical records for each case-managing CHN will be reviewed by a PRAH supervisor to verify there is accurate and complete medication documentation in the clinical record.

2) If a record is incomplete, this clinical record will be reviewed with the clinician and the record will be amended.

3) Any revisions or additions to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow-up chart audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur are as follows:

1) 100% of the PRAH clinical staff will attend an educational in-service regarding policy 0080A (Documentation in the Clinical Record). A copy of the policy will be distributed to the clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of charts for assigned staff members to ensure completeness of clinical records and appropriateness of follow up with MD of changes in the plan of care.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include an indicator to measure compliance of the clinical record including complete medication records.

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date will be 10/31/09

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484.52(b) – Clinical Record Review

At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both open and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.

Debra Lyda RN, BSN– Director – Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

- Issue #1 – The issue being that the record review was completed by nursing alone.
  - PRAH will submit to the PRAH Professional Advisory Committee (PAC) recommendations for membership on the Utilization Review Committee for PAC approval. Membership will include nursing, medical social work, physical therapy, occupational therapy, speech pathology therapy, respiratory therapy, and nutrition. These disciplines represent all the health professionals who practice within the scope of the PRAH program.
  - PRAH will review and /or revise policy 0003A –Utilization Review Committee with reference to membership and attendance responsibilities.
- Issue #2 - There was a lack of documentation of a sample of both active and closed clinical records that were reviewed by the Professional Advisory Committee on a quarterly basis.
  - PRAH will review and/or revise policy 0003A Utilization Review Committee with reference to the Utilization Review Committee as a sub committee of the Professional Advisory Committee.
  - PRAH will review with the Professional Advisory Committee policy 0003A Utilization Review Committee once policy is reviewed and/or revised.

To identify other patients having the same potential to be effected by this deficiency, the following corrective action will be taken:

All patients would be affected by this deficiency. Corrective action stated above.

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The systemic changes that will be implemented to ensure that the deficient practice does not reoccur are as follows:

- Utilization Review Committee membership and meeting attendance will be reviewed quarterly (4) times annually to ensure compliance to proper representation on committee and compliance with attendance requirements.

- If any issues are identified, membership changes will be facilitated per policy 0003- Utilization Review Committee.

- Annually PRAH will review with all Utilization Review Committee members the attendance responsibility per policy 0003- Utilization Review Committee.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

- Audit Utilization Review Committee membership and meeting attendance quarterly, (4) times annually, as part of the Park Ridge at Home quality improvement plan.

Completion date will be 10/31/09.

G 337

Attachment # 15

484.55(c) - Drug Regime Review

The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug interactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Debra Lyda, RN, BSN– Director – Park Ridge at Home (PRAH) is responsible for correction and ensuring continued compliance.

Corrective action to be accomplished for the patient affected by the deficiency is as follows:

1) The PRAH supervisor will meet one-on-one with each clinician involved with the clients identified in this deficiency: clients: 2,6,8,11,14, and 15. The PRAH supervisor will discuss the standard not met as evidenced by the CHN failing to maintain an accurate medication profile and review what actions should have transpired to ensure a complete and accurate plan of care was in place. The PRAH supervisor will complete an in-home supervisory visit with each clinician to assess performance.

The one-on-one clinician counseling and chart review sessions will include discussion and education on the policies and the importance of adhering to the policies as it relates to the following specific patient issues:

Client # 2: Review to complete the medication profile at every visit, add any new or changed medication information to the electronic medical record whenever the staff learns of a medication change. The medication list will generate an order and also a supplemental order to confirm medication changes with the MD.

Client # 6: Review when medications are discontinued from medication profile that the associated problem needs to be discontinued also. This will generate an order and supplemental order that the MD will sign.

Client # 8: Review medications with client at every visit, add medication to medication profile as needed. This will generate an order and supplemental order that the MD will sign.

Client # 11: Review medications with client every visit, also include medication that client is taking over the counter and at another facility. This will generate an order and supplemental order that the MD will sign.

Client # 14: Review medications with client at every visit, add medication to medication profile as needed. This will generate an order and supplemental order that the MD will sign.

Client # 15: Review medications with client and/or family member managing medications for an accurate medication profile and complete plan of care. If there is a discrepancy noted, MD needs to be contacted for clarification.

2) The PRAH supervisor will review each client's chart and compare the documentation and observations from the above supervisory home visit with the current plan of care. The observations will be reviewed with the clinician and any inaccuracies found in the plan of care will be corrected. Any revisions or updates to the plan of care will be sent to the MD.

To identify other patients having the same potential, and the corrective action to be taken as follows:

1) 20% of the medical records for each case managing CHN will be reviewed by PRAH supervisor to verify there is evidence that the CHN maintains an accurate medication profile.

2) If a record is found with an incomplete plan of care, these observations will be reviewed with the clinician and the plan of care will be corrected.

3) Any revisions or additions to the plan of care will be sent to the MD. If a trend is noted with a particular clinician, the same level of review and training will occur as described in #1 above under corrective action, including an in-home supervisory visit and follow-up chart audit and review.

The systemic changes that will be implemented to ensure that the deficient practice does not reoccur is as follows:

1) 100 % of PRAH clinical staff will be required to attend an educational in-service to review policies 0049A (Medical Policies, standard Medical Regimes and Standing Orders), 0080A (Documentation in Clinical Record) and 0049E (Medication Administration). A copy of the policies will be distributed to the clinical staff. This in-service will be repeated annually.

2) On an ongoing basis, PRAH supervisors will audit 10% of the clients' records for the assigned staff members to ensure completeness of orders for medications and to ensure the plan of care is followed as ordered.

To monitor the success of the corrective action in order to ensure the deficient practice will not reoccur, PRAH will implement the following:

1) The Utilization Review Committee will audit clinical records quarterly using a 20% sample size. The clinical records will be selected equally from each clinical team.

2) The Utilization Review Tool that will be used will include an indicator to measure accuracy and completeness of the clinical record for medications

3) The results of this audit are reported quarterly to the PRAH Professional Advisory Committee.

Completion date 10/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337251	A. BUILDING _____ B. WING _____	C 12/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY SETON HOME CARE CORP	14 APPLETREE BUSINESS PARK CHEEKTOWAGA, NY 14227

(X3) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 000	Initial Comments This statement of deficiencies is the result of the Title XVIII/XIX Article 36 complaint investigation (NY#00094900) conducted by the staff of the Western Regional Office of the New York State Department of Health on 12/06/10 and 12/07/10. Three (3) clinical records were reviewed and agency staff was interviewed.	G 000		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and interview with agency staff, in one (1) of three (3) clinical records, agency staff failed to coordinate the patient care effectively to support the objectives outlined in the plan of care. The issue is failure to recognize the need for an coordinate skilled nursing visits daily to perform the wound care as the caregivers available were not qualified to perform such care. The agency failed to ensure that the skilled nurse made arrangements to set up the patient's medications and to ensure that these were administered as ordered. The patient affected was 1. Findings are: Patient 1 - This [redacted] year-old patient with diagnoses that include stage II decubitis ulcer buttocks, hypertension and osteoarthritis was admitted to the home care agency on 09/13/10. According to the Plan of Care (POC) for the	G 143	"Coordination of Patient Services" and the limited scope of care that can be provided by unlicensed agency staff will be reviewed with the Clinical Managers and all clinicians at mandatory educational sessions. Education will include the need to ensure that only qualified individuals are incorporated into the patient care plan for hands on care such as bathing, grooming, dressing, incontinence care, medication set up and administration or wound care. Clinicians will be reminded to demonstrate tasks and observe caregiver re-demonstration when appropriately incorporated into the care plan. Clinical Managers will be educated on how to access the NYSDOH data base of approved licensed agencies when agency status is in question. Clinical Managers will also be advised to review tasks assigned to caregivers outside of the certified agency during case conferences to ensure that only qualified individuals are incorporated into the patient's care plan. If necessary, alternate arrangements will be discussed with the clinician, patient and/or patient's family.	March 1, 2011 Completed 1.13.11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Joyce A. McAuley / Pres/CEO 1/12/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient's. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337251	A. BUILDING _____ B. WING _____	C 12/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY SETON HOME CARE CORP	14 APPLETREE BUSINESS PARK CHEEKTOWAGA, NY 14227

(X3) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 143	Continued from Page 1 certification period of 09/13/10 to 11/11/10, wound care was to be performed to the decubitis ulcer daily as follows, "Cleanse wound with mild soap and H2O (water), dry peri-wound area. Apply skin protectant to peri-wound area and wound bed utilizing clean technique. CG (caregiver) independent with wound care". At the SOC (start of care) on 09/13/10, assessment, the Registered Nurse (RN) noted that the patient "has intermittent confusion. Orient to name". The initial assessment indicated that the patient required assistance with bathing and grooming, medication administration and performance of medical treatment such as wound care. According to the documentation, the "caregiver currently provides". The RN indicated that the patient's "son lives in Texas. Pt (patient) has Assisting Angels 7 days a week 11-2 and 6 - 9. Aide states that she assists the pt with ADL's (activities of daily living) and at night assist getting pt to bedtime". The RN further documented in the clinical record that the caregiver "assists pt with weekly med set up". According to the documentation, the nurse instructed the caregiver signs and symptoms of infection and incontinence care and that the caregiver was providing assistance with "(M2100) d. Medical procedures treatment (e.g. change wound dressing)". There was no evidence of nursing visits on 09/14, 09/16, 09/18, 09/19, 09/20, 09/22 and 09/23/10 to perform the daily wound care. At the nursing visit on 09/17/10, new wound care orders were obtained which directed that "CG to perform on non SN (skilled nursing) days". The wound care ordered was daily cleansing with soap and water and application of Calmoseptine ointment to the wound . On 09/21/10, the nurse documented	G143	The Agency's comprehensive audits will monitor documentation of coordination of services. The Director of Patient Services is responsible for implementation of this Plan of Correction.	Ongoing

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	337251	A. BUILDING _____ B. WING _____	C 12/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY SETON HOME CARE CORP	14 APPLETREE BUSINESS PARK CHEEKTOWAGA, NY 14227

(X3) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 143	Continued from Page 3 teaching the wound care to the caregiver. At the nursing visit on 09/24/10, the nurse documented the presence of 2 additional open areas. New wound care orders were obtained at that time. The current orders were to continue until the new wound care supplies were obtained. The nurse documented that she "taught and instructed the patient and caregiver skin breakdown prevention". There was no evidence that care was coordinated to include nursing visits on 09/25, 09/26, 09/27 and 09/28/10 to perform the daily wound care. According to NYCRR 10 Section 765.2-1Issuance of a License. (a) No home care services agency, other than those exempt from licensure requirements as provided in subdivision (c) of the section, shall provide nursing, home health aide of personal care services in their home unless it has been approved by the Public Health Council and has been issued a license pursuant to the provisions of article 36 or the Public Health Law and this Part". The companion agency providing care for the patient is not a Licensed Home Care Agency or Certified Home Health Agency in New York State. The individuals employed by this agency are only able to provide companion care to their clients. These employees are not trained to provide hands on care. These employees cannot provide bathing, dressing, incontinence care, medication set up and administration or wound care. Interview was conducted with the Director of Patient Services (DPS), Vice-President of Clinical Services and the Vice-President of Operations on 12/07/10 and the findings were presented. The	G143		

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G 143	Continued from Page 3 DPS was aware that the "companion agency" should not be provide hands on care. It was acknowledged that the home care staff needed to be educated regarding what tasks can be assigned to these non-skilled companion aides as part of the patient's plan of care and what more appropriate options might be employed to meet the patient's needs.	G143		

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	337251	A. BUILDING _____ B. WING _____	R-C 01/29/2010

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MCAULEY SETON HOME CARE CORP	14 APPLETREE BUSINESS PARK CHEEKTOWAGA, NY 14227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS This Statement of Deficiencies is a result of the Title XVIII/XIX Article 36 post certification survey and complaint investigations #NY00077348 and #NY00076746 conducted by the staff of the Western Regional Office of the New York State Department of Health on 01/27 and 01/28/2010. During the survey, five (5) clinical records were reviewed.	{G 000}		
{G 159}	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status; types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review , staff interview and agency policy and procedure, the agency failed in four (4) of five (5) clinical records to ensure that the plan of care developed was of sufficient scope to meet the patient's needs. The issues are failure to identify dietary nutrition for a diabetic patient, failure to refer to skilled nursing services, lack of identification for diabetic management of a diabetic patient, lack of specific doses for medication, lack of identification of responsible person for administration of vitamin injections, lack of identification of a stump shrinker, lack of identification for as needed (PRN) reasons for medications, lack of orders for Physical Therapy and Social Services, lack of pain medication	{G 159}		1/24/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Fisher — TITLE: DOPS — (X6) DATE: 2-1-10

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(G 159)	Continued From page 1 order, lack of diagnoses and lack of assistance with medicatiions. Failure of staff to develop a plan of care to meet all of the patient's needs has the potential for agency staff to act on incomplete/inaccurate information that could result in the provision of inappropriate care. Patients affected are 1, 2, 3 and 5. Examples include: Patient 5 - This [redacted] year-old patient with diagnoses that include Hypertension, Kidney Disease and Anemia was admitted to the agency on 01/25/2010. The skilled nursing opening visit on 01/25/2010 determined that the patient used a magnifying glass along with her glasses to read pill bottles. The MO1200 vision assessment included documentation that the patient was partially impaired and "cannot see medication labels or newsprint". The MO2020 identified that the patient was " able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. There was no evidence in the clinical record that the nurse included medication assistance in the plan of care. The OT (Occupational Therapy) visit on 01/27/2010 identified under the "self care note", that the "patient has Macular Degeneration, decreased vision, uses magnifying glass". The Plan of Care also did not include the diagnoses of Macular Degeneration. Interview with the President/CEO and the Director of Patient Services on 01/28/2010 provided no further information. Patient 1 - This [redacted] year-old with diagnoses that	(G 159)		

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{G 159}	Continued From page 2 include [redacted] diabetes and hypertension was admitted to the home care agency for physical therapy services on 01/25/10. The Home Health Certification and Plan of Care (POC) for 01/25/10 to 03/25/10 failed to include direction for diabetes management and Vitamin B12 administration. The 01/25/10 start of care visit note stated the patient's blood sugar was "85". The POC for 01/25/10 to 03/25/10 lacked direction about performance of glucometer measurements including who would perform, the frequency of performance and parameters for reporting to the physician. Dietary restrictions related to the diabetes were not included or identified. Medication orders for insulin administration were incomplete. The POC directed the patient receive both Lantus and Humalog insulin. Both the Lantus and Humalog insulin orders lacked specific doses. In addition, the Humalog insulin order stated a frequency of "intermittent as needed depending on blood sugar levels". The order lacked the specific frequency that the blood glucose was to be monitored and under what circumstances the insulin would be needed. This POC also directed the patient receive Vitamin B12 injections. The POC failed to identify who was to administer these injections. The need for a skilled nursing referral to further evaluate the patient's diabetic status and its management as well as management of the Vitamin B12 injections was not identified in the clinical record or included on the POC. Interview with the President/CEO and Director of Patient Services on 01/28/2010 provided no further information. Patient 3 - This [redacted] year-old with diagnoses that include shoulder pain, chronic obstructive	{G 159}		

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{G 159}	Continued From page 3	{G 159}		

pulmonary disease and hypertension was admitted to the home care agency on 01/25/10. The Home Health Certification and Plan of Care (POC) for the certification period 01/25/10 to 03/25/10 was incomplete. The Patient Referral dated 01/22/10 stated the patient had been hospitalized for left shoulder pain. According to the Start of Care (SOC) Nursing visit dated 01/25/10, the patient's left shoulder pain was rated as a five (5) of ten (10) that interfers daily with activity or movement. The POC lacked an order for pain medication. At the (SOC) the nurse documented the patient required a urinary catheter to address urinary incontinence. The POC did not include direction or an order for this intervention. The nurse identified on the initial nursing visit that the patient was on a "cardiac" diet. The POC lacked the specific dietary restrictions that this entails. The nurse's initial assessment also identified the need for a referral to physical therapy for shoulder pain and balance problems as well as a referral to a medical social worker for long term care planning needs. According to the nurse's documentation, the patient agreed to both services. The POC did not identify that referrals were obtained for these services.

The POC directed the patient to use Ventaolin inhaler and oxygen "prn" (as needed). Evidence was lacking under what circumstances the patient was to use this medication and/or the oxygen.

Interview with the President/CEO and Director of Patient Services on 01/28/2010 provided no further information.

New York State Department of Health

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J 000	Initial Comments This Statement of Deficiencies is a result of the Title XVIII/XIX Article 36 post certification survey and complaint investigations #NY00077348 and #NY00076746 conducted by the staff of the Western Regional Office of the New York State Department of Health on 01/27 and 01/28/2010. During the survey, five (5) clinical records were reviewed.	J 000		
J 508	763.5(a)(1-2) Patient Referral and Admission 763.5 Patient Referral and Admission. (a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless: (1) the patient's authorized practitioner orders otherwise; or (2) there is written documentation that the patient or family refuses such a visit. This Regulation is not met as evidenced by: Based on record review and interview with agency staff, the agency failed to ensure in one (1) of five (5) clinical records that care was initiated within 24 hours of acceptance of the referral or discharge from a facility. There is the potential for development of unrecognized complications prior to admission to the home care agency placing the patient's health at risk. The patients affected are 1.	J 508		

Office of Health Systems Management / Office of Long Term Care

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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J 508	Continued From page 1 Findings are: Patient 1 - This [redacted] year-old with diagnoses that include [redacted] diabetes and hypertension was admitted to the home care agency for physical therapy services on 01/25/10. According to documentation in the clinical record, the patient was referred to the agency on 01/21/10 by the physician with a start of care date of 01/22/10. A "Case Communication" note dated 01/25/10 by the physical therapist (PT) stated the patient was "contacted on 1/23/10 to set up appointment for PT eval (evaluation) on 1/25/10." This was a lapse of three (3) days between the requested start of care date and the initial skilled phyical therapy visit. An interview was conducted with the President/CEO and Director of Patient Services on 01/28/10. No additional information was provided.	J 508		

Plan of Correction for Statement of Deficiencies
Title XVIII/XIX Article 36 Post Certification Survey and Complaint #NY 00077348 and #NY00076746
1/27 & 1/28/2010

G:000 Initial Comments:

The Administrator will ensure that the Board of Directors are notified of the statement of Deficiencies resulting from the Title XVXIII/XIX Article 36 Post Certification Survey and Complaint #NY 00077348 and #NY00076746 and the Plan of Correction to correct the identified deficiencies.

G159 – 484.18 (a) Plan of Care

To ensure the Plan of Care is followed as specified in G 159 484.18 The Director of Patient Services will ensure the following actions.

Corrective Action(s) For This Deficiency:

The survey stated that this standard was not met in 4 out of 5 clinical records.
Per regulation the clinical staff has five (5) days to complete their assessment from the Start of Care Date. In the four (4) records that were identified with deficient practices the documentation was incomplete. The clinical staff case conferenced the Start of Care with the Clinical Manager and the documents were completed and locked per regulations.

Patient #1 Please refer to attachment A for completed Plan of care that was faxed to Nancy Davis on 1/29/2010.

Patient#2, Please refer to attachment B completed 485, attachment C clinical note, and D physician order for venipuncture, both faxed to Nancy Davis on 1/29/2010.

Patient #3, Please refer to Attachment E Plan of Care, F page 4 0f 19 0f SOC assessment, and G page 5 of 19 of SOC assessment faxed to Nancy Davis on 1/29/2010.

Patient #5, Please refer to attachment H completed Plan of Care and Attachment I page 3 of 9 all faxed to, attachment I faxed to Nancy Davis on 1/29/2010.

Corrective Actions to Ensure Deficient Practice will not recur:

a. PI will audit 10% of daily census quarterly to include a sampling of Start of Care, Resumption of Care, Recertification, and Discharge patient clinical records. The audit findings will be reviewed by the individual team manager with the DPS and the Director of Quality at regularly scheduled meetings. Audit results will also be forwarded to the PAC with their recommendations provided to the Board of Directors. — Ongoing

b. 100% of adverse events will continue to be reviewed monthly and reported to PAC four times a year. This information is also forwarded to the appropriate clinical supervisor for discussion with identified clinician to increase awareness and provide education/counseling as needed. — Ongoing

Monitoring Actions to Ensure Deficient Practice will not recur:

a. The results of the data will be aggregated and reviewed monthly at the clinical managers meeting with the DPS. The data findings will be brought back to the teams by the individual clinical managers. For clinicians who fail to meet audit thresholds, progressive disciplinary actions will occur per agency policy. The results of the audit will be presented to the Professional Advisory Committee on a quarterly basis. The results and recommendations will be forwarded to the Board of Directors at regularly scheduled meetings or more frequently as — Ongoing

defined by the Board of Directors or CEO.

b.	Supervisory home visits will be completed by the Clinical Manager a minimum of 3 times per week, with copies of the Staff Performance Field Observation forms to the DPS for monitoring and storage.	1/24/10 & Ongoing
c.	DPS will perform home visits to supervise clinical managers 4 times per month or more frequently as needed.	1/1/10 & Ongoing

J508 ~ 763.5(a)(1-2) Patient Referral and Admission

To ensure the HHA comply with the regulation of receipt and acceptance of community referrals or return home from institutional placement within 24 hours the Director of Patient Services will ensure the following actions.

Corrective Action(s) For This Deficiency:

a.	Patient #1 Identified clinician counseling regarding the 24 hour regulation of all community referrals or return home from institutional placement.	2/28/2010
b.	All staff will be educated in the next scheduled team meeting regarding the 24 hour acceptance of community referrals or return home from institutional placement.	2/28/2010

Corrective Actions to Ensure Deficient Practice will not recur:

c.	All staff will be educated in the next scheduled team meeting regarding the 24 hour acceptance of community referrals or return home from institutional placement.	2/28/2010
d.	PI will audit 10% of daily census quarterly to include a sampling of Start of Care and Resumption of Care.	ongoing
e.	A report that identifies referral vs. Start of care will be run bimonthly to ensure compliance with the 24 hour regulation of all community referrals or return home from institutional placement to ensure compliance. The clinical manager will be notified of any delays and will provide further clinical education or counseling.	ongoing

Monitoring Actions to Ensure Deficient Practice will not recur:

a.	PI will audit 10% of daily census quarterly to include a sampling of Start of Care and Resumption of Care.	ongoing
b.	A report that identifies referral vs. Start of care will be run bimonthly to ensure compliance with the 24 hour regulation of all community referrals or return home from institutional placement to ensure compliance. The clinical manager will be notified of any delays and will provide further clinical education or counseling	ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 000	INITIAL COMMENTS This statement of deficiencies is the result of the Title XVIII/XIX Article 36 complaint investigation NY#00072705 conducted by the staff of the Western Regional Office of the New York State Department of Health on 06/04/09, three (3) clinical records were reviewed and agency staff was interviewed.	G 000		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, review of agency policy and procedure and interview with agency staff, the agency failed in three (3) of three (3) clinical records to ensure that the staff followed the plan of care established by the physician. The issues are failure to perform pulse oximetry measurements, wound assessments and care, and assessment and care of PICC (peripherally inserted central catheter) line sites as ordered by the physician. There is the potential to place the agency patients at risk for improper or inadequate assessment and/ or care. The patient affected are 1, 2, and 3. Findings are: Patient 1 - This [redacted] year-old patient was admitted to the home care agency on 03/14/09 with diagnoses that included Diabetes Mellitus Type II with foot ulcer and peripheral vascular disease. The agency nursing staff did not follow orders for	G 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Fisher RN BSN DOPS | TITLE | (X6) DATE: 7/2/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 158	Continued From page 1 wound care. According to the Plan of Care (POC) for the certification period of 03/14/09 to 05/12/09, the nurse is directed to perform wound care to the foot ulcer as follows: "Daily cleanse wound with NS (normal saline) Dakins solution. Pack R (right) heel WD (wound) with Dakins dampened 1/2" (half inch) plain packing and cover with Dakins dampened folded 4 x 4 and wrap with Kerlix." At the visits on 03/16/09 and 03/19/09, the nurse documents in the clinical record that the wound was cleansed with wound cleanser, was packed with plain gauze and was covered with wet to dry Dakins "soaked gauze. At the visit on 03/18/09, the documentation indicates that the wound was cleansed with normal saline and was packed with 50% Dakins soaked gauze strips. A dry sterile dressing and Kerlix were then applied to cover the wound. The POC directs the nurse to provide care to the patients peripherally inserted central venous catheter (PICC) by cleansing the site with alcohol three times, followed by Betadine three (3) times and to cover with transparent dressing. The circumference of the bicep, ten (10) centimeters above the insertion site, and the external length of the catheter are to be measured when line care is provided. The nursing staff documents on 03/17/09, 03/24/09, 03/31/09, 04/07/09, 04/27/09, 05/04/09, 05/18/09, and 05/26/09 that the PICC site was cleansed with Chlorhexidine/Chlorpro. There are no measurements of the bicep or the external length of the catheter documented in the clinical record on the visit conducted on 03/24/09. At the ROC (resumption of care) on 04/24/09, the documentation identifies an incision in the right groin and on the right leg. The ROC orders direct the nurse to "perform and instruct patient with the	G 158		

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G 158	Continued From page 2 measurement of incision to right groin and leg." At the visit on 05/06/09, the documentation indicates that the right groin is healed but the right leg incision has scant serosanguinous drainage. There is no further assessment of the right leg incision or care to this area documented at the visits conducted between 05/06/09 and 06/03/09. The POC for the certification period of 05/13/09 to 07/11/09 directs the nurse to obtain a pulse oximetry measurements "every scheduled visit." There is no evidence in the clinical record of a pulse oximetry measurement for the visits of 05/18, 05/22, 05/29, 06/01, and 06/03/09. The agency policy titled "Pulse Oximetry Monitoring" (06/30/06) was not followed. The policy states, "it is the policy of MSHC (McAuley Seton Home Care) to use pulse oximetry per physician order." Interview with the Quality Manager and the Supervising Nurse on 06/04/09 confirmed that wounds are to be measured weekly and that measurements of PICC sites are to be obtained when performing care to the insertion site. They agreed that the order for PICC line care did not include the use of Chlorhexidine. No further information was provided regarding the assessment of the right leg incision or the lack of pulse oximetry measurements. Patient 2- this [redacted] year-old patient with diagnoses that include Diabetes Mellitus type II with foot ulcer and peripheral vascular disease was admitted to the home care agency on 04/21/09. According to the Plan of Care (POC) for the certification period of 04/21/09 to 06/19/09, the patient is to have a baseline pulse oximetry measured. There is no evidence that this	G 158		

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G 158	Continued From page 3 measurement was performed at the start of care visit on 04/21/09. The agency policy titled "Pulse Oximetry Monitoring " (06/30/06) was not followed. The policy states, "it is the policy of MSHC (McAuley Seton Home Care) to use pulse oximetry per physician order." The POC directs the nurse to measure the patient's foot ulcer weekly. There is no documented evidence of wound measurements between 04/21/09 and 05/13/09. The nurse did not follow the agency policy titled "Wound Management and Treatment Policy" (01/16/09) which states "record wound measurements weekly." Interview with the Quality Manager and the Supervising Nurse on 06/04/09 presented no further information to refute these findings. Patient 3 - This -year-old patient with diagnoses that include Diabetes Mellitus Type II with foot wound and hypertension was admitted to the home care agency on 05/30/08. The Plan of Care (POC) for the certification periods of 03/26/09 to 05/24/09 and 05/25/09 to 07/23/09 directs the nurse to "measure the wound q (every) week". There is no evidence in the clinical record of weekly measurements of the foot ulcer. Specifically, there are no measurements of the wound documented on the visit notes for the weeks of 04/05/09 to 04/11/09 and 04/12/09 to 04/18/09. There is no evidence of wound measurements for the nursing visits between 04/26/09 and 05/22/09. The nurse did not follow the agency policy titled "Wound Management and	G 158		

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G 158	Continued From page 4 Treatment Policy" (01/16/09) which states "record wound measurements weekly." Interview with the Quality Manager and the Supervising Nurse on 06/04/09 presented no further information to refute these findings.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of clinical records, agency policy and procedures and interview with agency staff, the agency failed in two (2) of three (3) records to ensure that the plan of care developed is of sufficient scope to meet the patient's needs. The issues are performing pulse oximetry measurements without physician orders, and incomplete wound VAC orders. Failure to develop plans or care of sufficient scope to meet the needs of the patient has the potential for agency staff to act on incomplete or inaccurate information. The patients affected are 1 and 3. Findings are: Patient 1- This [redacted] year-old patient was admitted to the home care agency on 03/14/09 with diagnoses that included Diabetes Mellitus type II	G 159		

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G 159	Continued From page 5 with foot ulcer and peripheral vascular disease. Oxygen saturation levels were measured on the patient on 03/14/09, 03/18/09, 04/07/09, 04/24/09, 5/01/09,5/06/09 and 05/08/09. There are no orders for measurements of pulse oximetry or for parameters to notify the physician on the Plan of Care (POC)(for the certification period of 03/14/09 to 05/12/09. The agency policy titled "Pulse Oximetry Monitoring" (06/30/06) was not followed. The policy states, "it is the policy of MSHC (McAuley Seton Home Care) to use pulse oximetry per physician order." The policy further states, "Verify Physician order" ans "Notify physician with SpO2(saturation of peripheral oxygen) value when:- SpO2 value is outside the physician ordered parameter." A resumption of care (ROC) visit was performed on 04/24/09. The orders change the wound care to a wound VAC (Vacuum Assisted Closure) system. The orders lack the type of foam to use for wound packing. The agency policy and procedure titled, "Negative Pressure Wound Therapy" (07/15/08) identifies two different types of foam for wound dressing with the VAC system. Each type of foam has different recommended uses. "Black, polyurethane foam has reticulated pores, is hydrophobic (moisture repelling) to enhance exudate removal." VAC Versa Foam. "It is generally recommended for situations where the growth of granulation tissue into the foam needs to be more controlled or when the patient can't tolerate the black foam due to pain." Interview with the Quality Manager and the Supervising Nurse on 06/04/09 confirm that orders should be obtained for pulse oximetry and the type of foam to be used in performing care	G 159		

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G 159	Continued From page 6 with a wound VAC should be included in the orders. Patient 3 - This -year-old patient with diagnoses that included Diabetes Mellitus Type II with foot wound and hypertension was admitted to the home care agency on 05/30/08. At the nursing visits on 04/07/09, 04/10/09, 04/14/09, 04/17/09, 04/21/09, 04/24/09, 05/05/09, 05/11/09, 05/15/09, and 05/19/09. the nurse documents use of pulse oximeter to measure oxygen saturation levels. The Plan of Care for the certification periods of 03/26/09 to 05/24/09 and 05/25/09 to 07/23/09 lack orders for the measurements of oxygen saturation and parameters to notify the physician. The agency policy titled "Pulse Oximetry Monitoring" (06/30/06) was not followed. The policy states., "It is the policy of MSHC (McAuley Seton Home Care) to use pulse oximetry per physician order." The policy further states, "Verify Physician order' and Notify physician with SpO2(saturation of peripheral oxygen) value when: SpO2 value is outside the physician ordered parameter." Interview with the Quality Manager and the Supervising Nurse on 06/04/09 confirmed that orders should be obtained for pulse oximetry.	G 159		

Plan of Correction for Statement of Deficiencies
Complaint # NY0007270
6/4/09

G:000 Initial Comments: The Director of Patient Services will ensure that the Board of Directors are notified of the statement of deficiencies resulting from the complaint # NY00072706 and the Plan of Correction to correct the identified deficiencies.

G:158 484.18 Acceptance of Patients, POC, Med Super.

To ensure that McAuley Seton and its staff comply with the Professional Standards and principles that apply to professionals furnishing services in the Certified Home Health Agency (CHHA), the Director of Patient Services will ensure the following actions.

Patient #1. A case conference will be conducted by the Clinical Nurse Manager of the Infusion Team for the purpose of education and quality patient care. This case conference will include education for writing complete and accurate Physician orders, wound care documentation per McAuley Seton's policy and procedure, and maintenance for peripherally inserted central venous catheters (PICC) including care of the insertion site, bicep measurement and external catheter measurement. The case conference will be mandatory for all nursing staff involved in the care of this patient. Completion date 7/31/09.

To ensure compliance the Clinical Nurse Manager will re-educate the entire infusion team on McAuley Seton's policy for Wound Management and Maintenance for Peripherally inserted Central Venous Catheters and PICC maintenance will be added to the record review tool.

To ensure continued compliance with the POC the Clinical Nurse Manager and/or the Performance Improvement Department will complete a random sample of chart audits including no less than two charts of the clinical staff who were involved in the deficient practice. Re-education will be provided for all deficient practices identified which could include home supervisory visits and disciplinary action by the Clinical Nurse Manager. The completion date for the clinician specific chart audits and supervisory visits will be completed by 8/31/09.

To ensure ongoing compliance and to identify other patients having a potential to be affected by the same deficient practice, the Clinical Nurse Manager will perform quarterly chart audits of no less than 10% of the Infusion Team census. These audits are due by month end of the quarter.

The Clinical Nurse Manager will review and re-educate the entire Infusion Team on McAuley Seton's Pulse Oximetry policy and procedure, to ensure understanding that a physicians order is necessary to perform pulse oximetry. This will be completed by 8/31/09.

To ensure ongoing compliance and identify other patients having a potential to be affected by the same deficient practice, the Clinical Nurse Manager will audit on a quarterly basis no less than 10% of the Infusion Team census. These audits are due the month the quarter ends. Pulse oximetry monitoring will be added to the audit tool by 7/31/09.

Patient #2. Chart reviewed with the nurse who was responsible for the deficient practice by the Clinical Nurse Manager of the team. McAuley Seton's policy and procedure for pulse oximetry, and wound management and treatment reviewed which includes weekly wound measurement. Re-education and counseling provided by the Clinical Nurse Manager. Completed 6/09.

To ensure deficient practice by the nurse does not reoccur chart audits of no less than two charts will be completed by 8/31/09 by the Clinical Nurse Manager and or the Performance Improvement Department. If the deficient practice is identified further disciplinary action will be taken.

To ensure ongoing compliance and identification of other patients having a potential to be affected by the same deficient practice quarterly chart audit of no less than 10% of the team census will be completed by the Clinical Nurse Manager. Quarterly audits are due the month the quarter ends.

Patient #3. The Clinical Nurse Manager reviewed the clinical record with all clinical staff assigned to the case. The Clinical Nurse Manager provided re-education for the team during the team meeting. This education included wound measurement per McAuley Seton policy of Wound management and treatment. This was completed 6/09

To ensure and monitor for deficient practices related to wound management a focus audit will be performed by the Clinical Nurse Manager of the team and/or the Performance Improvement Department. The focus audit will include no less than 2 charts each of the clinical staff who were involved with the care of this patient. Further education and/or disciplinary action will be taken if deficient practices are again identified. Clinical staff were informed of this procedure in the 6/09 team meeting. Focus wound audits will be completed 8/31/09.

To ensure ongoing compliance and identification of other patients having the potential to be affected by the same deficient practice the Clinical Nurse Manager will complete quarterly chart audits of no less than 10% of the team census per quarter. Quarterly audits are due the month the quarter ends.

G159 484.18 (a) Plan of Care:
Patient #1 Case will be reviewed by the Clinical Nurse manager with the clinical staff that provided care for this patient. The team will receive re-education on McAuley Seton's policy for Pulse oximetry monitoring that will include obtaining and verification of physician orders and physician notification for saturation of peripheral oxygen levels that are outside of parameter ordered by the physician. This will be completed by 7/31/09

To ensure compliance to McAuley Seton's policy and quality of patient care the Clinical Nurse Manager will audit no less than 2 charts each of the clinical staff who were involved in the deficient practice. This will be completed by 8/31/09.

To ensure ongoing compliance and identification of other patients having the potential to be affected by the same deficient practice the Clinical Nurse Manager will complete quarterly chart audits of no less than 10% of the team census per quarter; the audit tool will be revised to include Pulse Oximetry Monitoring. The change to the audit tool will be completed 7/31/09 Quarterly audits are ongoing and are due the month the quarter ends.

Patient #1. Resumption of care for Vacuum assisted closure. The Clinical Nurse Manager will review the chart with the clinical staff involved with the care of this patient. Re-education will be provided on vacuum assisted closure (VAC). This will be completed by 7/31/09. The infusion team shall receive re-education on McAuley Seton's policy on Negative Pressure Wound Therapy which will include obtaining accurate physicians orders for the type of foam to used for the patient's dressing with VAC. This will be completed by 8/31/09.

To ensure ongoing compliance the Clinical Nurse Manager will complete a focus audit on VAC patients for her team. The clinical Nurse Manager will create a list of patients with VAC therapy from this list she will audit 10% of the charts. If the team does not have patients that are receiving VAC therapy, the Clinical nurse Manager will complete a focus audit on any new patient admitted to the team with this type of therapy. The focus audit shall continue for a 6 month period of time and be completed by 1/31/10.

To ensure ongoing compliance and identification of other patients having the potential to be affected by the same deficient practice the Clinical Nurse manager will complete not less than 10% quarterly chart audits per team census. These audits are due the last month of the quarter. VAC therapy will be added to the wound audit toll.

Patient #3. The Clinical Nurse Manager for the team will complete a chart review with all of the clinical staff who were involved with the deficient practice. The review of the chart will include re-education on McAuley Seton's policy on Pulse Oximetry Monitoring. This was completed 6/09. The Clinical Nurse Manager will provide re-education on McAuley Seton's policy for Pulse Oximetry Monitoring at the team meeting. This was completed 6/09.

To ensure compliance Pulse Oximetry will be added to the chart audit tool. The Clinical Nurse Manager and or Performance Improvement Department will audit no less than 2 charts from the clinical staff who were involved in the deficient practice. Progressive disciplinary action will begin if the deficient practice is repeated. Completion date 8/31/09.

To ensure ongoing compliance and identification of other patients having a potential to be affected by the same deficient practice the Clinical Nurse Manager will perform quarterly chart audits of no less than 10% of the team census. These chart audits are to be completed by the last month in the quarter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 000	INITIAL COMMENTS This Statement of Deficiencies is a result of the Title XVIII/XIX Article 36 complaint Investigation (CO#NY00049767) conducted by staff of the Western Regional Office of the New York State Department of Health on 11/06/070 & 11/07/07. Five (5) clinical records were reviewed and agency staff was interviewed	G 000	The Director of Patient Services (DOPS) will ensure that the Board of Directors is notified of the Statement of Deficiencies resulting from the Title XVIII/XIX Article 36 complaint investigation (#NY00049767) at the next regularly scheduled Board Meeting.	Q1/2009 1/2008
G 109	484.1(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to participate in the planning of care. The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment. This STANDARD is not met as evidenced by: Based on clinical record review and staff interviews, the agency failed in tow (2) of five (5) clinical records to ensure that the patient participated in the discharge plan. Failure of the agency to ensure that the patient participates in formulating the discharge plan has the potential to place the patients at risk for not receiving the care needed to meet their goals and remain safely in the community. The patients affected are 1 and 2. Findings are: Patient 1 - this [redacted]-year-old patient with diagnoses that include foot cellulitis, [redacted] deep vein thrombosis (DVT), and neurogenic bladder was admitted to the agency on 9/1/07. The plan of care (POC) for the certification period of 9/1/07 to 10/30/07 indicated that the nurse was to visit	G 109	To ensure that the patient is advised of their right to participate in planning the care or treatment and in planning changes in the care or treatment. Discharge planning. A care review was completed on the patient. Education was provided to the clinical manager, and the staff involved, on all aspects of discharge planning. An assessment and	11/2007

SIGNATURE Paula Fisher TITLE Director of Patient Care (X6) DATE 12-27-07

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB NO. 0938-0391

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G 109	Continued From page 1 every Monday, Wednesday and Friday to administer a soap suds enema. On 10/22/07 and 10/24/07, the clinical documentation indicates that the skilled nursing visit was being made to instruct the patient in performing the soap suds enema on himself. The patient was unable to complete the procedure and the nurse administered the enema as ordered. At the visit on 10/26/07, the nurse documented in the clinical record that the patient was "unable to prepare or perform the enema on himself". There is no documented evidence that further attempts were made to instruct the patient in this procedure. There is no evidence that the patient was included in developing a plan as to how the enemas would be provided upon discharge from the agency. A certified letter was sent to the patient on 10/23/07 advising him that his certified home care services would be discontinued effective 10/30/07. Provisions were arranged by the physician for the patient to have his wound care managed at a wound care clinic according tot the letter. However, there was no indication in the letter that arrangements were made for the patient's enema. There is no indication in the clinical record as to whether the patient received the letter or when. On 10/30/07, the skilled nurse, to arrange for the discharge visit placed a call, to the patient. According to the documentation in the clinical record, the patient became very upset and stated that the agency "cannot discontinue services". The patient was discharged from care on 10/31/07. No discharge visit was made and the discharge instructions were to be mailed to the patient, according to the documentation in the clinical record. There is no documented evidence that a plan was in place to provide for the patient's enemas upon discharge.	G 109	evaluation was completed on the patient who was readmitted to service on 11/8/07. Please refer to attached letter which outlines his plan of care and discharge process. Educational needs were identified and training and education will be developed. This education will include management understanding boundaries with patients and management of patients who exhibit or express inappropriate behavior and or language. **Addendum** **To ensure the deficient practice does not recur. Education will be developed on management of difficult patients and understanding and maintaining boundaries with patients. We will monitor this by review of patient complaint log and patient satisfaction log. The education will consist of a series of workshops that are scheduled to begin 02/08 and end in 06/08**	06/2008 12-31-07

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G 109	Continued From page 2 Interview conducted with the Director of Patient Services on 11/7/07 at 12:00 PM confirmed that the patient had been discharged without a complete plan for continued care. Patient 2- This [redacted] year-old patient with diagnoses that include leg cellulitis, acute renal failure and diabetes mellitus type II, was admitted to the agency on 8/17/07. According to the plan of care (POC) for the certification period of 8/17/07 to 10/15/07, the patient is independent with daily wound care and the skilled nurse was to assess the wound at each weekly visit. At the start of care (SOC) visit on 8/17/07, the clinical record indicates that the patient has three wounds: left posterior calf, right posterior calf and the right front leg. The wounds did not improve as evidenced by the documentation of the visits 9/26/07 and 10/3/07. The clinical record indicated that the "lower left extremity wound is much larger" and the "lower right extremity wound has some yellow tissue with blackened tissue along the edges". On 10/11/07according to the clinical record, the skilled nurse contacted the patient to arrange a home visit. "the client refused the visit today" and the nurse instructed the patient that "she must get to a MD. MD won't change the order unless she sees client". The clinical documentation then indicated that the patient was discharged on 10/11/07 with goals met according to the Discharge Summary. The goal of the POC was that "the patient's wound will demonstrate measurable granulation, remain free from infection and heal without complications". It was unclear from the documentation, why the patient had been discharged as she had refused the one visit 10/11/07. there is no documented evidence in the clinical record that the nurse had discussed with the patient, a discharge plan for continued	G 109		
		Patient 2	Chart will be reviewed with the clinical staff involved in providing care. This education will include wound care orders and supplies. Discharge criteria education will be provided at team meeting for all clinical nursing staff.	01/2008
			A wound care team is being being developed. This wound team will manage identified ICD 9 wounds. the team consists of four WCC and will train team members on wound modalities and supply management.	02/2008
			<u>Addendum</u> **Compliance will be monitored by chart audits. Educational needs will be provided through identified trends, chart audits are 10% per clinical team per quarter. Staff who continue with deficient practice will be placed on a corrective action plan that is monitored by the clinical manager.**	on-going

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G 109	Continued From page 3 assessment and monitoring of the wounds or that the discharge was imminent. Interview conducted with the Director of Patient Services on 11/7/07 at 12:00PM presented that she did not know why the patient had been discharged when it appeared, according to the clinical record, that the wounds continued to need monitoring and intervention.	G 109		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and staff interviews, in two (2) of five (5) clinical records lacked evidence that care coordination occurred to ensure that all patient needs are met. Failure of the agency to arrange for patient care needs, as part of a discharge plan, failure to coordinate care provided by agency staff and failure to assist the patient in obtaining consultation with the physician. The patients affected are 1 and 2. The findings are: Patient 1- This [redacted] year-old patient with [redacted] diagnoses that include foot cellulitis, deep vein thrombosis (DVT) and neurogenic bowel and bladder was admitted to the agency on 9/1/07. The plan of care (POC) for the certification period of 9/1/07 to 10/30/07 indicated that the nurse was to visit every Monday, Wednesday and Friday to administer a soap suds	G 143	Director of Patient Services (DOPS) will ensure that all personnel furnishing service maintain liaison to ensure coordinated patient services. Patient 1 Chart of Patient 1 will be reviewed with clinical managers and staff involved who provided care. Client's case was reviewed and re-opened on 11/8/07. Please refer to attached letter for Plan of Care and evaluation. Education will be provided at team	11/07 01/2008

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G 143	Continued From page 4 enema. On 10/22/07 and 10/24/07, the clinical documentation indicates that the skilled nursing visit was being made to instruct the patient in performing the soap suds enema on himself. The patient was unable to complete the procedure and the nurse administered the enema as ordered. At the visit on 10/26/07, the nurse documented in the clinical record that the patient was "unable to prepare or perform the enema himself". The patient was discharged from care on 10/31/07. the discharge summary documents, "Patient unwilling to attempt soap suds enema independently." there is no documented evidence that coordination of care occurred for the arrangements to manage the administration of the enema to the patient after discharge from the agency. Interview conducted with the Supervising Community Health Nurse (SCHN) on 11/17/07 at 9:15 AM presented that she has a conversation with the patient on 10/5/07. At that time he had advised her that he had done the enemas in the past but stopped when he developed a sacral decubitus. The nursing staff at that time feared that he might contaminate the wound. Even though the wound was healed, he never resumed the enemas on his own; "he didn't like the idea of doing it". The SCHN also advised that he had exceptional upper body strength, able to transfer himself in and out of the tub and was able to disimpact himself. She has spoken with the physician regarding the issue of the patient's enema and advised that the physician felt the patient could do this for himself. The SCHN acknowledged that she did not document the conversations with the physician or the patient on 10/5/07 and that the patient has not demonstrated independence with the procedure prior to	G 143	meetings by the clinical manager. on development of plans for care and discharge planning. Coordination of care process will be reviewed and redesigned. Please refer to attached process. Clinical teams will be educated on coordination of services by the clinical manager at team meetings. **Addendum** **Compliance will be monitored by comprehensive chart audits. Education will be provided through identification of trends in the chart audits. Staff who continue with deficiencies will receive progressive discipline after educational needs are identified and sufficient education provided. Associates who are identified as needing further education will have Home Visits with their clinical supervisor and be placed on a progressive action plan monitored by the clinical manager.**	12/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3372	A. BUILDING _____ B. WING _____	C 11/07/07

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G 143	Continued From page 5 discharge from the agency. The SCHN confirmed that further arrangements to assist the patient with this procedure at the time of discharge had not been made. Patient 2- This [redacted] year-old patient with diagnoses that include leg cellulitis, acute renal failure and diabetes mellitus type II, was admitted to the agency on 8/17/07. According to the plan of care (POC) for the certification period of 8/17/07 to 10/15/07, the patient is independent with daily wound care and the skilled nurse was to assess the wound at each weekly visit. At the start of care (SOC) visit on 8/17/07, the documentation indicates that the patient has wounds bilateral posterior calves that are draining large amounts of serosanguinous drainage. There is a third wound on the front of the right leg that was draining scant serous drainage. The patient was also noted to have 3+ edema in the left leg and 2+ edema in the right leg. At the skilled nursing visit on 8/29/07, the clinical documentation prese5ns that the Licensed Practical Nurse (LPN) noted that the wounds on the front of the right leg and the right calf had large amounts of purulent drainage and edema was 4+ bilateral lower extremities. There was no assessment of the wound on the left calf documented. On 9/5/07, the LPN indicated small to moderate amount of purulent drainage from the wounds. There is no documented evidence that the LPN notified the nurse case manager after either of these visits regarding the increase in edema or the presence of purulent drainage from the wounds so that the case manager could assess the wounds and edema and consult with the physician regarding a possible change in the plan of care.	G 143		
		Patient 2	LPN competency for wound care has been developed. This includes a pre and post test. All LPNs will be educated and each much achieve an 85% on the post test to be qualified for wound care.	01/2008
			All clinical staff will be educated on coordination of care and documentation by the clinical manager at team meetings.	01/2008
			A wound team is in the development stage. This team will manage all identified wounds from chosen ICD 9 will case manage wounds and supplies. The wound team consists of 4 WCC and 2 LPNs and 3 RNs who demonstrate competency with wound care. This competency includes patient care, documentation, and coordination of care.	02/2008
			Addendum **Monitoring will be done through on-going continued comprehensive record audits; 10% per team per quarter. Education will be developed from identified trends. Staff who continue to be deficient will be placed on a progressive action plan that is monitored by the clinical manager.**	on-going 12-31-07

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G 143	Continued From page 6 On the visits of 9/12/07 and 9/18/07, the LPN documented that the patient was attempting to set up an appointment with an Infectious Disease Specialist to check her legs. There is no documented evidence that this was discussed with the nurse case manager or that attempts were made to facilitate the patient in arranging the appointment. Interview conducted with the Director of Patient Services on 11/7/07 at 12:00 PM presented no further information.	G 143		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review and staff interviews, two (2) of five (5) clinical records lacked evidence that agency staff follow the plan of care as ordered by the physician. The issues are no following wound care orders and failure to obtain an order to discharge a patient. The failure to follow a written plan of care has the potential to place patients at risk for inadequate and improper care. The patients affected are 1 and 2. The findings are: Patient 1- This [redacted]-year-old patient with diagnoses that include foot cellulitis, [redacted] deep vein thrombosis (DVT) and neurogenic bowel and bladder was admitted to the agency on 9/1/07. The plan of care (POC) for the certification period of 9/1/07 to 10/30/07 indicated	G158	The DOPS will ensure that patient care is delivered per the plan developed for the patient and reviewed with the physician. The chart was reviewed with the clinical manager and the staff who were involved with the plan of care. Education will be provided by the clinical manager to the clinical team at team meetings. This education will include development of a plan of	12/07

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G 158	Continued From page 7 wound care to the pressure ulcer left heel and ankle as follows: cleanse with normal saline, calcium alginate, dry sterile dressing (DSD) daily. At the skilled nursing visit on 9/12, 9/13, 9/14, 9/15, and 9/17/07, the nurse documents that the heel and ankle wounds were packed with Silver Sorb Gel Calcium alginate and dry clean dressing (DCD) was applied. There is no order fro the use of Silver Sorb Gel for packing the wounds and the original order was fro DSD to be applied. On 9/26/07, a new order for wound care tot the left heal and ankle was received. The order stated, "Wound care to left heel, irrigate with normal saline, apply calcium alginate, cover with DSD every other day and as necessary." On 10/2/07, an order was received to continue with the same treatment. At the skilled nursing visit on 10/10/07, the nurse documents that Santyl and a DSD was applied to the left heel. There is no order for the application of Santyl to the wound. Application of a different wound care product has the potential to result in an adverse reaction. There was no documentation in the clinical record that the physician was notified of a change in the wound care products in either of these situations. Interview was conducted with the Director of Patient Services on 11/7/07 at 12:00 PM and no further clarification was presented. The plan of care (POC) indicated that the nurse was to visit every Monday, Wednesday and Friday to administer a soap suds enema. Attempts to teach the patient to self-administer these enemas, was done on 10/22, 10/24 and 10/26/07 according tot the clinical record. At the visit on 10/26/0 the nurse documented in the clinical record that the patient was "unable to prepare or perform the enema himself". On	G 158	care and following the plan of care. also changes to the plan of care will be reviewed with the physician. Education will also be provided to the clinical staff about patient competence with treatment. Patients must demonstrate independence and competence or a family member prior to discharge. Education will be provided to the clinical team by the clinical manager regarding early discharge process. **Addendum** **Monitoring will be done through chart audits. Education will be developed from identified trends. Staff who continue with deficient practice after education is provided will be on a progressive action plan. Monitored by the clinical manager.**	12/07 Accepted 1-8-08 10.31.07

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G 158	Continued From page 8 10/22/07, according to the Case Communication report in the clinical record the Senior community Health Nurse (SCHN) contacted the physician regarding inappropriate behaviors manifested by the patient which made it difficult to render care. The physician advised that the patient "had been inappropriate with his office and nursing staff, and continues to be non-compliant with treatment". According to the documentation, the physician wanted to be kept "informed about the situation". On 10/31/07, the patient was discharged from the agency. The agency had a prescription from the physician for the patient to have his wounds treated at a wound clinic but this did not contain an order to discharge the patient. There is no documented evidence in the clinical record of an order from the physician to discharge the patient from services. Interview conducted with the SCHN at 9 AM on 11/7/07 presented that she had spoken with the physician regarding difficulties with the patient but had not written a verbal order to discharge the patient: Interview conducted with the Director of Patient Services (DPS) on 11/7/07 at 12PM confirmed that the patient should have been discharged if there was an incomplete discharge plan or without an order for the physician. Patient 2- This [redacted] year-old patient with diagnoses that include leg cellulitis, acute renal failure and diabetes mellitus type II, was admitted to the agency on 8/17/07. According tot the plan of care (POC) for the certification period of 8/17/07 to 10/15/07 indicates that the skilled nurse is to visit the patient weekly to assess wound status and measure wounds. The wound care consisted of cleansing the sounds with sterile normal saline, applying saintly, Telfa and a	G 158	Case will be reviewed with the clinical staff involved with the care of the patient and education will be provided on wound competency. A wound team is in the development process. This team will manage all designated wounds within an established ICD 9 criteria. LPN competency for wound is in progress.	12/07 02/2008

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G 158	Continued From page 9 dry sterile dressing (DSD). The client demonstrated independence with the wound care according to the POC. At the start of care (SOC) visit 8/14/07, the clinical record indicates that the patient has three wounds: left posterior calf, right posterior calf and the right front leg. At the visit of 8/29/07, there is no documented evidence that the left calf wound was assessed or that the wound care was completed to this wound. The nurse documented that the patient did her own wound care and applied Santyl, Telfa and DSD to this wound as well. On 9/12, 9/19, 9/26 and 10/3/07, it is unclear which wounds were assessed as the nurse documents assessment and measurements for only two wounds and describes their location as the right leg and the left leg. Review of the clinical documentation did not reveal the outcome of the two wounds there were not assessed. Interview conducted with the Director of Patient Services on 1/7/07 at 12:00 PM and no further clarification was presented.	G 158	All LPNs will be educated and a pre and post test will be used for evaluation purposes. **Addendum** **Monitoring will occur through on-going chart audits 10% per team per quarter. Trends will be identified and education will be provided. Staff who continue to demonstrate deficient practice will be placed on a progressive action plan monitored by the clinical manager.**	01/2008 on-going 12/31/07
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and staff interviews, the agency failed in two (2) of five (5) clinical records to inform the physician of changes in patient condition. The issues are failure to notify the physician in a timely manner of bleeding in a patient on anticoagulant therapy, failure to consult with the physician regarding the need to	G 164	DOPS will ensure periodic review of plan of care. Case review will be completed staff who were involved will be educated on review of chart and physician notification of change in condition.	12/07

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G 164	Continued From page 10 teach the patient to self-administer enemas, failure to consult with the physician regarding a need for therapy evaluations and failure to consult with the physician of worsening wound status. Failure to notify the physician of conditions that may require a change in the treatment plan has the potential to result in unmet patient needs and negative outcomes. The patients affected are 1 and 2. The findings are: Patient 1 -this [redacted] year-old patient with [redacted] diagnoses that include foot cellulitis, deep vein thrombosis (DVT) and neurogenic bowel and bladder was admitted to the agency on 9/1/07. according to the plan of care (POC) for the certification period of 9/1/07 to 10/30/07, the patient was to take Coumadin 5 milligrams (mg) on Monday, Wednesday, Friday and Saturday and 7.5 mg on Sunday, Tuesday and Thursday. He was also to be on bleeding precautions. The patient also had a peripherally inserted central venous catheter (PICC) in place for infusion of Vancomycin 1 gram (gm) intravenously every 12 hours. On 9/5/07, the patient's protime was 15.8 and INR of 1.3. According to the clinical documentation, the patient was to increase his comedian to 10 mg on 9/6/07 and 9/7/07, then resume the original doses. A repeat protime and INR were to be drawn on 9/10/07. at the visit on 9/7/07, the nurse documented in the clinical record, "PICC line bloody". The nurse performed PICC line maintenance per agency protocol. There is no documented evidence that the physician was contacted regarding the bleeding. On 9/8/07, the clinical record indicates that the	G 164	Coumadin process for best practice is in the development phase. This process will include patient teaching on anticoagulation, critical levels, and also use of new PT/INR machine, reporting of laboratory results, review by physician, also notification of the physician of abnormality such as bleeding at insertion site of PICC line. PICC line process and protocols will be reviewed with the clinician involved. Reporting of abnormal results will also be reviewed with the clinical staff who were involved in patient care. Education and review of the chart will be completed with the clinical manager and staff who were involved in patient care. Education for the staff involved on physician notification and physician review will be provided for the staff involved with this client's care.	02/2008 12/07 12/07

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G 164	Continued From page 11 patient had "bleeding from the PICC line, dressing saturated with blood, running down forearm. Patient also complained of pain right bicep area. Dressing changed to PICC line-compression applied and again it was noted that PICC line continued to bleed from the insertion site and down arm". At that time, nurse removed the PICC line. The physician was not notified until 9/10/07, according to the clinical documentation that the patient had experienced bleeding from the PICC insertion site on 9/7 and 9/8/07 and that the nurse removed the PICC insertion sit on 9/8/07. an elevated protime result of 30b with an INR of 2.2 was obtained on 9/10/07. No orders were obtained for change in the patient's Coumadin dosage or for follow-up monitoring of the elevated protime. The POC indicated that the nurse was to visit every Monday, Wednesday and Friday to administer a soap suds enema. On 10/22/07, the progress note in the Case Communication Report of the clinical record indicated that the skilled nursing visit was being made to instruct the patient in performing the soap suds enema on himself. Subsequent visits for this purpose were made on 10/24/07 and 10/26/07. There is no documented evidence that the physician had been consulting regarding the appropriateness of this plan. There is evidence of an order for this teaching. On 10/17/07, both the Physical Therapist and the Occupational Therapist visited the patient for the purpose of an evaluation. There is no evidence in the clinical record that a need for these evaluations had been discussed with or ordered by the physician.	G 164	**Addendum** **Monitoring will consist of on-going record audits, identification of deficient practice and re-education to staff. Clinical staff who have trends after education will receive a progressive action plan monitored by their clinical manager.**	on-going 10/31/07

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G 164	Continued From page 12 Interview was conducted with the Director of Patient Services on 11/7/07 at 12:00 PM and no further clarification was presented not these issues. Patient 2- This [redacted] year-old patient with diagnoses that include leg cellulitis, acute renal failure and diabetes mellitus type II, was admitted to the agency on 8/17/07. According to the plan of care (POC) for the certification period of 8/17/07 to 10/15/07, the patient is independent with daily wound care and the skilled nurse was to assess the wound at each weekly visit. At the start of care (SOC) visit on 8/17/07, the documentation notes that the patient has wounds bilateral posterior calves that are draining large amounts of serosanguinous drainage. There is a third wound on the front of the right leg that was draining scant serous drainage. The patient was also noted to have 3+ edema in the left leg and 2+ edema on the right leg. At the skilled nursing visit on 8/29/07, the clinical documentation presents that the nurse noted that the wounds on the front of the right leg ant the right calf had large amounts of purulent drainage and edema was 4+ bilateral lower extremities. There was no assessment of the wound on the left calf documented. On 9/5/07, the LPN indicated small to moderate amount or purulent drainage from the wounds. According to the clinical record, the wounds had not improved as evidenced by the documentation for the visits 9/26/07 and 10/3/07. The clinical record indicated that the "left lower extremity wound is much larger" and the "right lower extremity wound has some yellow tissue with blackened tissue along the edges". On 10/11/07, according to the clinical record, the skilled nurse	G 164	Case will be reviewed with the clinical manager and the staff who were involved with the care of this client. Education will be provided for all the clinical staff by the clinical manager on wound care documentation of wound progress, wound identification, and physician notification. Migration of wounds will be discussed. A wound team is in the developmental process that has 4 WCC RNs 2 LPNs who have demonstrated competency with wounds and have passed wound competency, and 3 other RNS who will be trained by the WCC RN's. This team will manage designated wound ICD 9's and provide case management documentation of wound progress and supply management. Care Coordination process developed Staff Education in progress. **Addendum** **Record audits will be completed on 10% of records for all clinical teams per quarter. Education will be provided on identified trends by either the clinical manager or staff development. Staff who continue to demonstrate deficient practice will be placed on a corrective action plan that will be**	12/07 02/2008 01/2008 on-going

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G 164	Continued From page 13 contacted the patient to arrange a home visit. "The client refused the visit today" and the nurse instructed the patient that "she must get to the MD. MD won't change order unless she sees the client." The clinical documentation the indicated that the patient was discharged on 10/11/07. According to the Discharge Summary in the clinical record, the nurse "wanted to change medical treatment and get culture since wound very slow healing. However MD wound not give orders and wanted client to see her". There is no documented evidence n the clinical record that the physician was notified of changes in the status of the patient's edema or wounds or the need for a change in the treatment plan, after any of these visits. There is no evidence that the nurse had obtained an order to discharge the patient from services. Interview was conducted with Director of Patient Services on 11/7/07 at 12:00 PM and no further clarification was presented. There s no documented evidence that the LPN notified the nurse case manager after either of these visits regarding the increase in edema or the presence of purulent drainage from the wounds so that the case manager could assess the wounds and edema and consult with the physician regarding a possible change in the plan of care.	G 164	**monitored by the clinical manager.**	
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by:	G 165	The DOPS will ensure conformance with physician orders. Cases will be reviewed and education will be provided by the clinical manager at team meetings on documentation and notification of physician orders.	12/07

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G 165	Continued From page 14 Based on clinical record review and staff interviews, the agency failed in two (2) of five (5) clinical records to ensure that medications were administered and that treatments were rendered in accordance with the plan of care. The issues are not following orders for wound care and assessment. The failure to follow physician's orders has the potential to result in provision of care outside of the physician's prescribed plan, which may have adverse outcomes. The patients affected are 1 and 2. See G158	G 165	**Addendum** **Chart audits will be completed on 10% of all records per clinical team per quarter. Education will be provided on identified trends. Staff who demonstrate continued compliance issues will be placed on a corrective action plan which will be monitored by the clinical manager.**	on-going
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information: name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that for two (2) of five (5) reviewed, the agency did not maintain clinical records for containing accurate and appropriate information. The issues are inconsistent documentation of the presence of and location of all wounds. There is a potential for agency staff to make incorrect decisions based on inaccurate information. The patients affected are 1 and 2.	G 236	The DOPS will ensure complete clinical records. Each record that was found deficient will be reviewed with the clinical manager. The documentation education will be provided to all clinical staff at the team meetings. LPN wound competency will be completed. A wound team is in the development process. This wound team consists of 4 WCC RN's 2 LPNs who demonstrate competency with wounds, 3 RNs who will be trained by the WCC RNs. This team will	01/2008 02/2008

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MCAULEY SETON HOME CARE CORP	**14 APPLETREE BUSINESS PARK CHEEKTOWGA, NY 14227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
G 236	Continued From page 15 Patient 1- This [redacted] year-old patient with diagnoses that include foot cellulitis, [redacted] deep vein thrombosis (DVT) and neurogenic bowel and bladder was admitted to the agency on 9/1/07. Throughout the documentation in the clinical record, the ordering of wound location by number was inconsistent. Examples are at the start of care (SOC) visit on 9/1/07, wound #1 was located on the left ankle and wound #2 was located on the left heel. A revised wound assessment document done 9/2/07, for the start of care indicates a third wound right flank area, this is labeled as wound #1. No other wounds are listed in this revised document. On the visit of 9/2/07, wound #1 is the left heel and the wound #3 is the right back. On 9/3, 9/4, 9/5 and 9/6/07, wound #1 is the right back and wound #3 is the left heel. On 9/2, 9/3, 9/4 and 9/5 and 9/6/07, the left ankle is labeled as wound #2. A consistent pattern for the labeling of the wound location was never established. Patient 2 - this [redacted] year-old patient with diagnoses that include leg cellulitis, acute renal failure and diabetes mellitus type II, was admitted to the agency on 8/17/07. Ordering of wound location was not consistent throughout the clinical record and all wounds were not assessed at each visit. Example are at the start of care visit on 8/17/07, the clinical record indicates that the patient has three wound: #1 left posterior calf, #2 right posterior calf and #4 the right front leg. At the visit on 8/29/07, there is no documented evidence that the left calf wound was assessed and wound #1 is now located at the right calf, wound #2 as the right front of the leg and wound #3 as the left calf and the presence of a new fourth wound on the anterior left lower extremity	G 236	manage designated ICD 9 wound cases. This management will include conference with the physician, appropriate wound management, documentation of wound progress, development of new wound processes and utilization of wound supplies. This team will also provide education on wounds to the other clinical teams in this agency. Record Audits will continue on all teams to ensure compliance and quality patient care. These audits will be completed by Performance Improvement and the clinical managers. **Addendum** **Education will be provided on identified trends. Staff who continue with deficient documentation will be placed on a corrective action plan that is monitored by the clinical manager.**	on-going on-going 12/31/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	C 11/07/07

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCAULEY SETON HOME CARE CORP	**14 APPLETREE BUSINESS PARK CHEEKTOWGA, NY 14227**

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G 236	Continued From page 16 was noted. On 9/12, 9/19, 9/26 and 10/3/07 it is unclear which wounds were assessed as the nurse documents assessment and measurements fro only tow wounds and describes their location as the right leg and left leg. Review of the clinical documentation did not reveal the outcomes of the tow wounds that were not assessed. Interview was conducted with Director of Patient Services on 11/7/07 at 12:00 PM confirmed that there is an identified problem with wound assessment and consistency of identifying the wounds. The agency is working on implementation of a new policy to address this.	G 236		

STATE OF NEW YORK
DEPARTMENT OF HEALTH

584 Delaware Avenue Buffalo, New York 14202

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

June 18, 2007

Mr. Mark Sullivan
McAuley Seton Home Care Corp.
14 Appletree Business Park
Cheektowaga, NY 14227

Re: Complaint **# NY00043421**

Dear Mr. Sullivan:

Please be advised that this office has received the investigative report relating to Western Regional Office of the New York State Department of Health complaint **# NY00043421**.

The report was found to be acceptable, and it is expected that you will implement the resolutions as stated. The Department reserves the right to reopen the investigation of this matter at some future time should additional evidence be provided or an appeal filed.

If you have any further questions regarding this matter you may call me at (716) 847-4320. Thank you for your cooperation.

Sincerely,

Margaret Jordan
Home Care Director
Western Regional Office/Buffalo

MMJ/tmc

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G 000	INITIAL COMMENTS This Statement of Deficiencies is result of a complaint investigation (Complaint #NY00078938) conducted by the staff of the Western Regional Office of the New York State Department of Health on 11/17/09 and 12/29/09. Four (4) clinical records were reviewed.	G 000		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure, and interview with agency staff, the agency failed to ensure in four (4) of four (4) clinical records that staff coordinated effectively to support the objectives outlined in the plan of care to ensure that the patient's needs were met. The issues are failure of the Registered Nurse (RN) to assess results of care provided by the Licensed Practical Nurse (LPN), failure of the telehealth LPN to consult with an RN regarding telehealth data and failure of the Physical Therapist to consult with the nurse regarding assessment findings. The RN case manager failed to coordinate timely care initiation by physical and speech therapists. The nurse failed to coordinate lab work as well as arrange for missing pieces of telehealth equipment. Failure to coordinate patient care and services may result in poor patient outcomes. The patients affected are 1, 2, 3, and 4. Findings are:	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 143	Continued From page 1 Patient 1 - This [redacted] year-old with diagnoses that include congestive heart failure, pulmonary fibrosis and Stage 1 pressure ulcer of the buttock was admitted to the home care agency on 10/28/09. The " Home Health Certification and Plan of Care" (POC) for the certification period 10/28/09 to 12/26/09 directed the telehealth nurse to perform daily home telehealth monitoring of pulse oximetry, weight, pulse and blood pressure and notify the physician of " trends outside of parameters." Both Registered Nurses (RN) and Licensed Practical Nurses (LPN) provided the telehealth monitoring. The clinical record lacked evidence of coordination between the telehealth LPN and the telehealth RN. According to the "Telehealth Communication Note Report" by the LPN for 11/10/09 through 11/13/09, the patient had pulse oximetry values outside the set parameters. In addition, the patient had a documented weight loss of 5.7 pounds between 11/03/09 and 11/10/09. There is no evidence that this information was communicated to either the telehealth RN or RN casemanager for analysis. The POC for the certification period 10/28/09 to12/26/09 directed the nurse to visit the patient twice weekly for two weeks, weekly for one week and then twice a month. The nurse was directed to perform at each patient visit an assessment that included cardiovascular, pulmonary and skin integrity status. According to the LPN home visit note for 11/15/09, the patient had abnormal lung sounds and refused to have his skin inspected. There is no evidence that the LPN communicated these issues to the RN to ensure that the patient's needs were met. Agency policy titled Case Management (Policy #SVC 212, effective date 11/30/06) states "B.The case manager is responsible for	G 143		

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G 143	Continued From page 2 coordinating care, which includes but is not limited to: 1. Coordination of all services directly or by contract provided to the patient by the agency, informal supports and other community resources to carry out the agency's plan of care. H. The secondary careproviders will relay to the case manager that information which is necessary for him/her to assure service integration." These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 2 - This [redacted] year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. At the physical therapy visit on 11/09/09, the therapist documented that the patient reported experiencing chest pain on 11/08/09 after negotiating stairs several times that day. There was no evidence in the clinical record that the physical therapist communicated with either the RN casemanager or the physician regarding this incident of chest pain. During phone contact with patient on the morning of 11/13/09, the telehealth RN documented the patient reported the symptoms of decreased appetite, increased thirst, blurred vision and had not taken the prescribed diabetic medication. In addition, the telehealth monitor had identified the patient sustained a five pound weight loss over the past seven days. The clinical record lacked evidence that the telehealth RN communicated the patient's reported symptoms and status to the RN casemanager to ensure coordination and follow-up of the patient's needs.	G 143		

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G 143	Continued From page 3 Agency policy titled Case Management (Policy #SVC 212, effective date 11/30/06) states "B.The case manager is responsible for coordinating care, which includes but is not limited to: 1. Coordination of all services directly or by contract provided to the patient by the agency, informal supports and other community resources to carry out the agency's plan of care. H. The secondary careproviders will relay to the case manager that information which is necessary for him/her to assure service integration." The agency staff failed to follow their own policy to ensure that patient ' s needs were met. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 3 - This [redacted] year-old with diagnoses that include status post cerebral vascular accident with dysphasia, congestive heart failure exacerbation with acute myocardia infarction, and atrial fibrillation was admitted to the home care agency on 10/27/09. The " Home Health Certification and Plan of Care" (POC) for the certification period 10/27/09 to12/25/09 directed the patient receive an evaluation by speech therapy. Evidence of care coordination between the RN casemanager and the Speech Therapist was lacking in the clinical record. The RN casemanager documented on the visit note dated 11/04/09 " patient awaits visit from speech therapist." There is no documented evidence that the RN casemanager communicated with the speech therapist regarding the planned date for evaluation. According to documentation in the clinical record, the speech therapist made the initial patient	G 143		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 143	Continued From page 4 contact by phone on 11/10/09, fourteen (14) days after the Start of Care (SOC). At an interview with the Director of Clinical Services (DCS) and Director of Quality Assurance (DQA) on 12/29/09, the DCS stated the agency expectation was that all ordered services would be initiated and a comprehensive POC developed within ten days of the SOC. The agency policy titled Case Management (Policy #SVC 212, effective date 11/30/06) states "B.The case manager is responsible for coordinating care, which includes but is not limited to: 1. Coordination of all services directly or by contract provided to the patient by the agency, informal supports and other community resources to carry out the agency's plan of care." There was a lack of coordination between the RN casemanager and the Speech Therapist resulting in a delay in the identification of the patient ' s total needs and timely development of a comprehensive POC. The patient had Coumadin 4 milligrams (mg) daily, ordered on the initial plan of care. On 11/02/09, a registered nurse (RN) performed a blood draw for a PT/INR (Prothrombin Time/International Normalized Ratio). There is no documented evidence of communication with the lab or the physician regarding the results of this blood work or the need for a change in the dosage of Coumadin. There was no documented evidence of communication between the RN Casemanager and the RN who visited 11/02/09 regarding the need for follow-up of lab results that may require a change in the patient's Coumadin. According to the 11/07/09 visit note, the RN documented performing a venipuncture for the following lab work: complete blood count, chemical screening, lipids, thyroid panel and digoxin level. There is no documented evidence of communication with the lab or the physician	G 143		

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G 143	Continued From page 5 regarding the results of this blood work or the need for a change in the POC as a result of this lab work. There was no documented evidence of communication between the RN casemanager and the nurse who visited on 11/07/09 regarding the need for follow-up of these lab results to determine the need for an alteration to the patient's POC. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided.	G 143		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of clinical records and interview with agency staff, the agency failed to ensure in three (3) of four (4) clinical records reviewed that the staff followed the plan of care established by the physician. The issues are failure to follow the ordered visit frequency, failure to notify the physician of telehealth data trends outside the ordered parameters, and failure to follow orders for medications and for assessment of blood pressure, weights, respiratory and skin integrity status. The nurse failed to observe/assess the patient's and caregiver's ability to use a glucometer and blood pressure equipment as well as failing to evaluate the patient ' s use of oxygen or medications as ordered. Failure to follow the established plan of care has the potential to place agency patients at risk for improper or inadequate care.	G 158		

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G 158	Continued From page 6 The patients affected are 1, 2, and 4. Findings are: Patient 1 - This year-old with diagnoses that include congestive heart failure, pulmonary fibrosis and Stage 1 pressure ulcer of the buttock was admitted to the home care agency on 10/28/09. The " Home Health Certification and Plan of Care" (POC) for the certification period 10/28/09 to12/26/09 directed the nurse to preform an assessment at each home visit that dyspnea levels, oxygen safety and management, and edema/weight. The nurse did not evaluate the patient's oxygen use at the 10/31/09 and 11/05/09 visits. During the 11/03 and 11/15/09 home visits, the nurse documented the patient was using the nasal oxygen at 5 Liters per minute. The POC directed the patient to use the nasal oxygen at 2 Liters per minute except during sleep and exertion when 5 Liters per minute was ordered. The documentation lacked evidence that the patient had exerted himself requiring an increase in the liter flow. There was no evidence in the clinical record that the nurse evaluated the reason for the patient's non-compliance with oxygen flow rate at the time of the home visit. The nurse also failed to assess the patient 's skin integrity on the visits of 11/03 and 11/05/09. According to 10/31/09 nursing visit documentation, the patient ' s weight was not assessed. The nurse failed to follow the plan of care established by the physician. The POC for the certification period 10/28/09 to12/26/09 directed the nurse to visit the patient twice weekly for two weeks, weekly for one week and then twice a month. The nurse failed to visit the patient during the week of 11/08 - 11/14/09 (the third week of the certification period) when	G 158		

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G 158	Continued From page 7 one home visit had been ordered. The nurse failed to follow the ordered visit frequency. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 2 - This [redacted] year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. The " Home Health Certification and Plan of Care " (POC) for the certification period 10/25/09 to12/23/09 directed the nurse to visit the patient three times between 10/25/09 and 10/31/09. According to documentation in the clinical record, the nurse visited the patient on 10/25/09 and10/27/09. No further visits were made to the patient until 11/04/09. The nurse failed to follow the ordered visit frequency during the first week of the certification period. The POC directed the nurse to preform an assessment at each home visit that included dyspnea levels. The nurse failed to evaluate the patient ' s level of dyspnea at the 11/04/09 and 11/06/09 home visits. A physician interim order dated 11/11/09 directed the patient discontinue Coumadin. There was no evidence in the clinical record that the patient had been instructed to discontinue the Coumadin. According to the Medication Summary in the clinical record, as of 11/17/09, Coumadin was listed as a current medication. The nurse failed to follow the physician order. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional	G 158		

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G 158	Continued From page 8 information was provided. Patient 4 - This [redacted] year-old with diagnoses that include hypertension, osteoarthritis, and hypothyroidism was admitted to the home care agency on 10/26/09. The " Home Health Certification and Plan of Care " (POC) for the certification period 10/26/09 to12/24/09 directed the nurse to visit the patient four times between 10/26/09 and 11/07/09. An interim physician order dated 11/03/09 changed the nursing visit frequency from four visits to five visits within the 10/26/09 to 11/07/09 timeframe. According to documentation in the clinical record, the nurse visited on 10/26/09, 10/29/09, 11/03/09 and 11/07/09. The nurse failed to meet the ordered visit frequency for this patient. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of clinical records and interview with agency staff, the agency failed in three (3) of	G 159		

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G 159	Continued From page 9 four (4) records to ensure that the plan of care developed was of sufficient scope to meet the patient's needs. The issues are unclear or incomplete medication, diet, and skilled nursing frequency orders, incomplete lab work orders, and orders for glucometer measurements including who is to perform and how frequently. The plans of care failed to include orders for the use of nutritional supplements, therapy services, as well as patient goals and interventions related to diabetes. Failure of staff to develop a plan of care to meet all of the patient's needs has the potential for unmet patient needs and possible negative patient outcomes. The patients affected are 1, 2, and 3. Findings are: Patient 1 - This [redacted]-year-old with diagnoses that include congestive heart failure, pulmonary fibrosis and Stage 1 pressure ulcer of the buttock was admitted to the home care agency on 10/28/09. The established " Home Health Certification and Plan of Care " (POC) for the certification period 10/28/09 to12/26/09 was incomplete. According to the Start of Care (SOC) nursing visit on 10/28/09, the patient used Ensure 1 can daily. This nutritional supplement was not included on the patient ' s POC. The 10/28/09 SOC Clinical Nursing Note stated that the patient had a Stage 1 pressure ulcer that was to be treated by irrigating the wound with normal saline and applying a transparent dressing twice a week. However, a " protective cream " was to be applied to this area until the patient received the dressing supplies. The POC did contain these pressure ulcer treatment interventions.	G 159		

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G 159	Continued From page 10 According to the SOC visit note for 10/28/09, the patient reported experiencing pain in back/hip joints for which the pain control measures of "rest and medication" were used. In the Clinical Findings section of the POC, the nurse documented the patient had complained of mild pain which was " relieved with Tylenol ". Tylenol was not listed as a current medication on the POC. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 2 - This year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. The established " Home Health Certification and Plan of Care " (POC) for the certification period 10/25/09 to12/23/09 was incomplete. According to the Referral Intake Summary dated 10/22/09, the patient had a diagnosis of Type 2 Diabetes of which the patient had a " vast knowledge deficit " . The Referral Intake Summary documented that the physician orders included instructing the patient on medication regimen and use of glucometer twice daily. Also the Referral Intake documented the patient ' s " Nutritional Requirements " as " Cardiac, ADA (American Diabetes Association) " . The " Home Health Certification and Plan of Care " (POC) for the certification period 10/25/09 to12/23/09 lacked direction for management of the patient ' s diabetes as follows: - the diet order present on the POC was a no added salt and low cholesterol diet; this diet order failed to specify an ADA restriction;	G 159		

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G 159	Continued From page 11 - blood glucose monitoring including the frequency, parameters and who was responsible for the monitoring was not specified as an intervention on the POC; The medication order for MiraLax on the "Home Health Certification and Plan of Care" (POC) for the certification period 10/25/09 to12/23/09 was incomplete. The POC directed the patient receive MiraLax 100% powder orally daily. The order did not define the specific amount of the MiraLax powder the patient was to take. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 3 - This year-old with diagnoses that include status post cerebral vascular accident with dysphasia, congestive heart failure exacerbation with acute myocardia infarction, and atrial fibrillation was admitted to the home care agency on 10/27/09. The established " Home Health Certification and Plan of Care " (POC) for the certification period 10/27/09 to12/25/09 was unclear and incomplete. According to the Referral Intake Summary dated 10/23/09, the physician had requested the patient receive an evaluation by physical, occupational, and speech therapy. The 10/27/09 POC lacked evaluation orders for both the physical and occupational therapy. There was no documentation in the clinical record for the reason these therapies may have been ommitted from the POC. According to the 10/27/09 POC, the patient ' s medications included Coumadin daily. The POC lacked the inclusion of safety measures for this medication. In addition, the order for the PT/INR	G 159		

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G 159	Continued From page 12 (Prothrombin Time/International Normalized Ratio) lab work was incomplete. The order lacked the specific frequency at which the lab work was to be obtained. The Start of Care (SOC) nursing assessment dated 10/27/09 stated the patient used Ensure 1 can daily. This nutritional supplement was not included on the patient ' s POC. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance (DQA) on 12/29/09. The DCS and the DQA agreed that the POC should have included evaluation orders for physical and occupational therapy, the use of ensure and safety measures relevant to Coumadin therapy. The skilled nursing visit frequency on the POC was unclear and confusing. There were two visit frequencies indicated on the POC for nursing. The first frequency directed the nurse to visit three times per week for two weeks, two times per week for two weeks, once per week for two weeks and then twice a month for two months. The second visit frequency directed the nurse to make five visits in the first two weeks, then one visit per week for two weeks and then twice a month for one month. It was unclear which visit frequency was to be followed. This finding was presented to the Director of Clinical Services (DCS) and Director of Quality Assurance (DQA) on 12/29/09. They stated that the computer program identifies a suggested frequency for visits based on the patient ' s diagnoses. However, the nurse after consultation with the physician must then input the individualized visit frequency for the patient. According to the DCS and DQA, the nurse failed to remove the computer generated visit frequency from the document.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF	G 164		

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G 164	Continued From page 13 CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, review of agency policies and procedures and interview with agency staff, four (4) of the four (4) clinical records, agency staff failed to notify the physician of changes in the patient's condition that may have resulted in a change in the plan of care. The issues are failure to notify the physician of trends in blood pressure, heart rate and pulse oximetry measurements outside the ordered parameters as well as blood pressure readings outside the patient's usual range. There was failure to consult with the physician regarding weight changes, changes in gastrointestinal and respiratory status, patient reported incidence of chest pain, patient noncompliance with the oxygen prescribed flow rate, and patient refusal for continued telehealth monitoring. There is the potential for complications to arise in the patient by not alerting the physician of changes in condition and this may result in negative patient outcomes. The patients affected are 1, 2, 3, and 4. Examples are: Patient 1 - This [redacted] year-old with diagnoses that include congestive heart failure, pulmonary fibrosis and Stage 1 pressure ulcer of the buttock was admitted to the home care agency on 10/28/09. The " Home Health Certification and Plan of Care " (POC) for the certification period	G 164		

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G 164	Continued From page 14 10/28/09 to12/26/09 directed the telehealth nurse to notify the physician " of trends outside of parameters " for " pulse under 50 or over 105 after medications " and " pulse oximetry less than 89% " . The telehealth data present in the clinical record for 11/04 through 11/06/09 documented that the patient's pulse oximetry ranged from 79% to 85% and the heart rate ranged from 106 to 121 beats per minute. There is no evidence in the clinical record that the physician was notified of these values. According to documentation in the clinical record for the period of 11/08 through 11/13/09, the patient ' s daily reported telehealth pulse oximetry ranged from 79% to 88%. Evidence was lacking in the clinical record that these pulse oximetry readings were discussed with the physician. On 11/14/09, the patient transmitted two sets of telehealth data. The results of the initial telehealth transmission reported a pulse oximetry of 78% and a heart rate of 116. The second transmission documented a pulse oximetry of 84% and a heart rate of 121. There is no evidence in the clinical record that the physician was notified of these values. The agency policy for the evaluation of telehealth trends was requested on 11/17/09 and again on 12/29/09. On both dates, the Director of Clinical Services (DCS) stated that the agency had no policy or definition for what constituted a trend. The DCS stated that the expectation was that the nurse would report to the physician the telehealth values that occurred outside any of the parameters for a three or four day period. The agency staff failed to meet this expectation. On the "SN (skilled nursing) Routine Revisit" note dated 11/05/09, the nurse documented that the patient ' s actual weight was 152 pounds. The	G 164		

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G 164	Continued From page 15 patient ' s previous weight documented on the11/03/09 " SN Routine Revisit " note was 164.7 pounds. This was a 12.7 pound weight loss over two days. There was no evidence in the clinical record the nurse discussed this weight loss with the physician. According to the telehealth data in the clinical record, the patient sustained a weight loss of 5.7 pounds over 7 days between 11/03/09 and 11/10/09. Evidence was lacking that the physician was consulted regarding the patient ' s unexplained weight loss. During the 11/03 and 11/15/09 home visits, the nurse documented that the patient was using the nasal oxygen at 5 Liters per minute. The 10/28/09 POC directed the patient to use the nasal oxygen at 2 Liters per minute except during sleep and exertion when 5 Liters per minute was ordered. The documentation lacked evidence that the patient had exerted himself requiring an increase in liter flow. There was no evidence in the clinical record that the nurse reported the patient ' s non-compliance with the oxygen flow rate to the physician. According to the " SN Routine Revisit " note for 11/15/09, the Licensed Practical Nurse (LPN) documented that the patient had rales in both the right and left lower lobes of the lung. Evidence was lacking that the physician was consulted with these findings. Agency policy titled Case Management (Policy #SVC 212, effective date 11/30/06) states " G. The case manager is responsible for assuring that the physician is notified regarding significant changes in the patient's status. NOTE: It is the professional responsibility of each careprovider to communicate to the physician that information which may warrant a change in the plan of care. " The agency staff failed to follow their own policy.	G 164		

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G 164	Continued From page 16 These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance (DQA) on 12/29/09. The DCS and the DQA agreed that the telehealth data findings met their expectation of a trend and the physician should have been consulted. No further information was offered related to the other findings Patient 2 - This year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. On 11/06/09 the nurse documented the patient reported no bowel movement in 3 days, had a history of constipation, and the patient ' s abdomen was distended and hard. The patient ' s medication regimen included both Ferrous Sulfate and Lortab whose side effects include constipation according to Nursing 2009 Drug Handbook, 29th edition, pages 52 and 481. The clinical record lacked evidence the physician was consulted about these symptoms to determine the need for a change in the Plan of Care (POC). At the physical therapy visit on 11/09/09, the therapist documented that the patient reported experiencing chest pain on 11/08/09 after negotiating stairs several times that day. There was no evidence in the clinical record that the physical therapist notified either the RN casemanager or the physician of this incident of chest pain. Agency policy titled Case Management (Policy #SVC 212, effective date 11/30/06) states " G. The case manager is responsible for assuring that the physician is notified regarding significant changes in the patient's status. NOTE: It is the professional responsibility of each careprovider to	G 164		

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G 164	Continued From page 17 communicate to the physician that information which may warrant a change in the plan of care. " The agency staff failed to notify the physician of changes in the patient ' s status that may have resulted in a change in the POC. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 3 - This [redacted] year-old with diagnoses that include status post cerebral vascular accident (CVA) with dysphasia, congestive heart failure (CHF) exacerbation with acute myocardia infarction (MI), and atrial fibrillation was admitted to the home care agency on 10/27/09. The "Home Health Certification and Plan of Care" (POC) for the period of 10/27/09 to 12/25/09 directed the patient receive daily home telehealth monitoring of blood pressure, pulse, weight and pulse oximetry. According to documentation in the clinical record, the home telehealth monitoring was initiated on 11/02/09. On 11/03/09 the patient ' s daughter contacted the RN Casemanager and requested discontinuation of the telehealth monitor because the patient was very overwhelmed. The RN Casemanager agreed to remove the telehealth monitor on the next scheduled home visit on 11/04/09. There was no documented evidence in the clinical record that the RN Casemanager consulted with the physician about discontinuing the telehealth monitor. The agency policy titled Case Management (Policy #SVC 212, effective date 11/30/06) states "B.The case manager is responsible for coordinating care, which includes but is not limited to: 1. Coordination of all services directly	G 164		

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G 164	Continued From page 18 or by contract provided to the patient by the agency, informal supports and other community resources to carry out the agency's plan of care. G. The case manager is responsible for assuring that the physician is notified regarding significant changes in the patient's status. NOTE: It is the professional responsibility of each careprovider to communicate to the physician that information which may warrant a change in the plan of care. " The RN Casemanager failed to notify the physician of a patient/caregiver requested change in the established POC. The 10/27/09 POC directed the nurse to assess the patient ' s blood pressure at every visit and report to the physician systolic blood pressure readings under 90 or over 164 and/or diastolic readings under 50 or over 90. The patient ' s documented blood pressure readings during the home visits were as follows: -10/27/09 home visit - blood pressure was 134/72 -10/30/09 home visit - blood pressure was 144/90 -11/02/09 home visit - blood pressure was 142/77 -11/04/09 home visit - blood pressure was 150/90 -11/07/09 home visit - blood pressure was 160/80 -11/16/09 home visit - blood pressure was 152/98 Although all the blood pressure readings with the exception of the last diastolic reading fell within the parameters, the nurse failed to recognize that the patient ' s systolic blood pressure readings were steadily increasing and failed to discuss this with the physician. The nurse also failed to report to the physician the patient ' s diastolic blood pressure of 98 on 11/16/09 that was outside the	G 164		

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G 164	Continued From page 19 parameters. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance (DQA) on 12/29/09. Both concurred that the expectation was that agency staff would report to the physician the occurrence of steadily increasing blood pressure readings even though the readings remained within the set parameters.	G 164		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure review, and interview with agency staff, four (4) of four (4) records lacked evidence that orders were obtained for changes in the plan of care. The issues are failure to obtain orders for telehealth monitoring, new or changed medications, and lab work. The failure to obtain signed physician orders for changes in the plan of care has the potential for agency staff to act on inaccurate information which may place the patient ' s health and welfare at risk. The patients affected are 1, 2, 3, and 4. Examples are: Patient 1 - This [redacted]-year-old with diagnoses that include congestive heart failure, pulmonary	G 166		

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G 166	Continued From page 20 fibrosis and Stage 1 pressure ulcer of the buttock was admitted to the home care agency on 10/28/09. According to the Case Communication Report note dated 11/05/09, the nurse received an order from the patient ' s primary care physician for the patient to take an " extra dose of 40 milligrams of Lasix this evening. " The clinical record lacked evidence a physician interim order was obtained for this extra dose of medication. In a Telehealth Communication Note Report dated 11/16/09 at 1:13 PM, the telehealth nurse documented the patient ' s pulse oximetry was below the set parameters at that morning ' s transmission and that the patient " will repeat transmission after breathing treatment. " The clinical record lacked evidence of a physician order for a " breathing treatment " . These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 2 - This [redacted] year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. According to documentation by the telehealth nurse on 11/04/09 and the physical therapist on 11/05/09, the patient had a telehealth machine installed in the home. The clinical record lacked evidence of a physician order for this service between 11/04/09 and 11/15/09 including what was to be monitored, the frequency for monitoring, and the parameters for each item monitored. Review of agency procedure titled Telehealth Monitoring (Procedure # 702, effective date 12/07/07) states	G 166		

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G 166	Continued From page 21 "A2. If home telehealth order if not already on the POC (485) [Plan of Care], clinician should contact the physician to obtain this order." The agency staff failed to follow their own policy for obtaining orders for this service. The " Home Health Certification and Plan of Care " (POC) for the certification period 10/25/09 to12/23/09 directed the patient receive Coumadin 4 milligrams daily. According to the Medication Profile, the patient's Coumadin order was decreased on 10/27/09 from 4 milligrams daily to 3 milligrams daily. The clinical record lacked evidence of a physician order for this change in dosage. On 11/11/09, an interim physician order directed the patient to stop taking Lortab and begin taking " Tylenol for pain ". This interim order was incomplete. The order lacked the dose and frequency for the Tylenol. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided Patient 3 - This [redacted]-year-old with diagnoses that include status post cerebral vascular accident with dysphasia, congestive heart failure exacerbation with acute myocardia infarction, and atrial fibrillation was admitted to the home care agency on 10/27/09. According to the 11/07/09 visit note, the nurse documented performing a venipuncture for the following lab work: complete blood count, chemical screening, lipids, thyroid panel and digoxin level. The clinical record lacked evidence of a physician order for this lab work. The interim physician order dated 11/13/09 was incomplete. The order stated " Per signed orders	G 166		

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G 166	Continued From page 22 from Dr. (name of physician) PT/INR (prothrombin time/International Normalized Ratio) standing order. " This order lacked the frequency that the PT/INR lab work was to be drawn. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided.	G 166		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on review of clinical records, agency policy and procedures, and interview with agency staff, evidence is lacking in four (4) of four (4) clinical records that the reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. The issues are failure to assess patient or caregiver's ability to demonstrate proficiency with glucometer, pulse rate, blood pressure and weight monitoring as well as failure to assess blood pressure and weights as ordered. The nurse performed incomplete drug review, respiratory, diabetic, wound and skin integrity assessments. The nurse failed to timely assess the effectiveness of medications prescribed for adventitious lung sounds and constipation as well as failed to evaluate patient data gathered by a Licensed Practical Nurse (LPN). There was failure to evaluate telehealth measurement trends and symptoms for indications requiring notification to the physician and Licensed Practical Nurses	G 172		

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G 172	Continued From page 23 performing assessments that are not within their legal scope of practice. Failure to perform complete and accurate nursing assessments has the potential for unmet patient needs. The patients affected are 1, 2, 3, and 4. Examples are: Patient 1 - This -year-old with diagnoses that include congestive heart failure, pulmonary fibrosis and Stage 1 pressure ulcer of the buttock was admitted to the home care agency on 10/28/09. The " Home Health Certification and Plan of Care " (POC) for the certification period 10/28/09 to12/26/09 directed the nurse to preform an assessment at each home visit that included edema/weight, skin integrity status, pulmonary status including dyspnea levels and oxygen safety and management, response to medications, and medication management. The nursing assessments/revisit assessments were incomplete as follows: -At the SOC visit on 10/28, the nurse identified that the patient had a Stage 1 pressure ulcer on the buttock. The nurse failed to assess the patient ' s skin integrity and the status of this pressure ulcer on the visits of 11/03 and 11/05/09. -According to the Case Communication Report note dated 11/05/09, the nurse received an order from the patient ' s primary care physician for the patient to take an " extra dose of 40 milligrams of Lasix this evening. " There is no evidence in the clinical record of phone contact with the patient or a follow-up visit by the nurse to determine if the patient had been compliant with the medication or if it had been effective. At the next home visit on	G 172		

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	337006	A. BUILDING _____ B. WING _____	C 12/29/2009

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G 172	Continued From page 24 11/15/09, the Licensed Practical Nurse (LPN) failed to follow-up on the patient ' s compliance with additional dose of Lasix. -According to the Telehealth Communication Notes for the period of 11/10/09 through 11/13/09, a LPN was assigned to review the submitted telehealth data. On each of these dates, the LPN documented that the patient "alerted" for either weight loss or gain and/or pulse oximetry below the set parameters. The LPN documented the results of the remaining data collected through telehealth monitoring and then stated the patient was "asymptomatic". There was no evidence that the LPN discussed these findings with a Registered Nurse so that the RN could evaluate if changes were needed to the plan of care. The LPN acted outside the legal scope of practice. According to the New York State Nurse Practice Act, Article 139, Section 692, Definition of Practice of Practical Nursing states that, "they may not interpret clinical data or act independently on such data," this is reserved for the Registered Professional Nurse. Therefore, the ability to assess and interpret the meaning of telehealth data outside the prescribed parameters is not within the scope of practice of the LPN. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 2 - This [redacted] year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. The nursing assessments/revisit assessments were	G 172		

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G 172	Continued From page 25 incomplete as follows: -According to the " Referral Intake Note Summary dated 10/22/09, the nurse was directed to."teach glucometer." According to documentation in the clinical record, the nurse saw the patient on 10/25/09 and 10/27/09. Neither of these nursing visit notes contained documentation that the nurse taught the patient or caregiver use of the glucometer. There also was no documented evidence in the clinical record that the patient or caregivers demonstrated proficiency with the glucometer procedure at the SOC or at the subsequent visits between 10/25/09 and 11/16/09. The Referral Intake Note Summary also stated that the patient has vast knowledge deficit re (regarding) DM (diabetes)." The " Home Health Certification and Plan of Care " (POC) for the certification period 10/25/09 to 12/23/09 directed the nurse to instruct on proper and safe use of medications. According to the POC, the patient's oral medication for diabetes, Metformin, was newly prescribed in the past 30 days. There was no documented evidence that the nurse assessed the patient ' s knowledge level and understanding of Metformin between 10/25/09 and 11/16/09. - The Plan of Care (POC) for the certification period of 10/25/09 to 12/23/09 directed that the patient ' s skin integrity be assessed each visit and the chest incision be treated with a dry clean dressing as needed. A visit by the registered nurse (RN) was made on 11/04/09. At that time the patient ' s chest incision was noted to be open and draining. On the subsequent visit on 11/06/09, the nurse failed to perform a complete assessment of the open incision site. The nurse documented " anterior thoracic incisions healing; old drain sites scabbing. " According to the agency ' s " Guidelines: Wound and Skin Care "	G 172		

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G 172	Continued From page 26 (revised 03/11/09) states " B1. Wound assessment done each visit. This assessment consists of: d. description of drainage: amount, color, consistency, odor. " The nurse failed follow agency guidelines in performing a complete assessment of the open wound. - On 11/03/09 the agency received a call from the patient's spouse. According to the Communication Note by the agency, the patient's spouse reported that the patient ' s surgeon, after seeing the patient earlier today, ordered an antibiotic for a wound infection. A visit by the registered nurse (RN) was scheduled for 11/04/09. There was no documentation in the 11/04/09 visit note that the nurse assessed the circumstances that may have lead to the development of the incision infection and developed a plan to prevent further occurrences. The nurse failed to perform an assessment of sufficient scope to identify possible unmet needs that could result in negative outcomes. -At the nursing visit on 11/06/09, the nurse documented in the clinical record that the patient had " no BM (bowel movement) in 3 days; has history of constipation; " and described the patient ' s abdomen as hard and distended. The nurse documented instruction on the purpose, action and side effects of Colace, Ferrous Sulfate, and MiraLax. There was no evidence in the clinical record of a follow-up visit or contact with the patient or spouse by the nurse until 11/11/09 to assess if the patient had been compliant with medication use or if the medication had been effective. - On 11/11/09, an interim physician order directed the patient to stop taking Coumadin. The patient was hospitalized from 11/13/09 to 11/15/09 for left pleural effusion. At the Resumption of Care nursing visit on 11/16/09, the	G 172		

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G 172	Continued From page 27 nurse documented the patient ' s medications were reconciled with the physician. According to the Medication Profile, Coumadin was a current medication for the patient since 10/27/09. There was no documentation in the clinical record that the Coumadin was resumed following the hospitalization. The nursing drug review assessment was unclear, incomplete and/or inaccurate related to the Coumadin status. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided. Patient 3 - This -year-old with diagnoses that include status post cerebral vascular accident with dysphasia, congestive heart failure exacerbation with acute myocardia infarction, and atrial fibrillation was admitted to the home care agency on 10/27/09. The nursing assessments/revisit assessments were incomplete as follows: - According to the visit note of 11/04/09, the nurse documented that the patient's daughter was to obtain a blood pressure cuff and scale so daily monitoring could be done. There was no documented evidence in the clinical record that the daughter demonstrated independence in performing blood pressure monitoring using proper technique or understood the need for consistency with weight monitoring. Specifically, at the subsequent visit on 11/07/09, the nurse did not assess for the availability of the blood pressure equipment or scale. There was also no evidence that the nurse assessed the daughter's knowledge level related to blood pressure and consistent weight monitoring or began some basic teaching about these procedures. The next	G 172		

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G 172	Continued From page 28 home visit was conducted on 11/16/09. The nurse documented at this visit that the " family is monitoring b/p (blood pressure)"; however, there was no evidence that the nurse evaluated if weights were being monitored. In addition, the documentation lacked evidence that the nurse assessed the blood pressure readings done by the family. These nursing assessments were insufficient in scope to identify possible unmet learning needs of the daughter and patient as well as to identify early changes in the patient's medical status. - According to the 11/07/09 visit note, the RN documented performing a venipuncture for the following lab work: complete blood count, chemical screening, lipids, thyroid panel and digoxin level. There was no documented evidence that the nurse obtained or contacted the physician for these results to determine if a change in the POC was needed based on the lab values. -The Plan of Care (POC) for the certification period of 10/27/09 to 12/25/09 directed the nurse to assess the patient ' s weight at each nursing visit. The nurse failed to assess the patient ' s weight at the visits on 11/07/09 and 11/16/09. Since daily home telehealth monitoring, which included a daily weight, was discontinued on 11/04/09, failure of the nurse to include a weight assessment during these home visits could have resulted in early symptoms of medical instability going undetected. These findings were presented to the Director of Clinical Services (DCS) and Director of Quality Assurance on 12/29/09. No additional information was provided.	G 172		

New York State Department of Health

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J 000	Initial Comments This Statement of Deficiencies is result of a complaint investigation (Complaint #NY00078938) conducted by the staff of the Western Regional Office of the New York State Department of Health on 11/17/09 and 12/29/09. Four (4) clinical records were reviewed.	J 000		
J 508	763.5(a)(1-2) Patient Referral and Admission 763.5 Patient Referral and Admission. (a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless: (1) the patient's authorized practitioner orders otherwise; or (2) there is written documentation that the patient or family refuses such a visit. This Regulation is not met as evidenced by: Based on review of the clinical records and interview with agency staff, the agency failed in two (2) of four (4) clinical records to ensure that care was initiated within 24 hours of acceptance of the referral or discharge from a facility. There is the potential for development of unrecognized complications prior to admission to the home care agency putting the patient's health and welfare at risk. The patients affected are 2 and 3.	J 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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J 508	Continued From page 1 The findings are: Patient 2 - This [redacted]-year-old with diagnoses that include severe coronary artery disease with four coronary artery bypass grafts, hypertension and non-insulin dependent diabetes was admitted to the home care agency on 10/25/09. The referral was received, by the agency on 10/22/09. The patient was discharged from the hospital on 10/23/09. The initial visit was not made until 10/25/09 after the agency received a phone call from the daughter inquiring about the start of care and expressing concerns about the patient's current status. There was no documentation in the clinical record that the patient refused a visit by the home care agency on 10/24/09. There was no evidence that the physician authorized 10/25/09 as the start of care. The findings were presented to the Director of Patient Services and Director of Quality Assurance on 12/29/09. They agreed that the first visit should have been made within twenty-four hours of receipt of referral. No further information was offered. Patient 3 - This [redacted]-year-old with diagnoses that include status post cerebral vascular accident with dysphasia, congestive heart failure exacerbation with acute myocardia infarction, and atrial fibrillation was admitted to the home care agency on 10/27/09. The referral was received on 10/23/09 with a start of care date for 10/24/09. The initial visit was not made until 10/27/09. There was no documentation in the clinical record that the patient refused a visit by the home care agency on 10/24/09. There was no evidence that the physician authorized 10/27/09 as the start of care.	J 508		

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J 508	Continued From page 2 The findings were presented to the Director of Patient Services and Director of Quality Assurance on 12/29/09. They agreed that the first visit should have been made within twenty-four hours of receipt of referral. No further information was offered.	J 508		

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G 000	INITIAL COMMENTS This Statement of Deficiencies is result of a complaint investigation (Complaint #NY00078938) conducted by the staff of the Western Regional Office of the New York State Department of Health on 11/17/09 and 12/29/09. Four (4) clinical records were reviewed.	G 000	Please see attached response.	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure, and interview with agency staff, the agency failed to ensure in four (4) of four (4) clinical records that staff coordinated effectively to support the objectives outlined in the plan of care to ensure that the patient's needs were met. The issues are failure of the Registered Nurse (RN) to assess results of care provided by the Licensed Practical Nurse (LPN), failure of the telehealth LPN to consult with an RN regarding telehealth data and failure of the Physical Therapist to consult with the nurse regarding assessment findings. The RN case manager failed to coordinate timely care initiation by physical and speech therapists. The nurse failed to coordinate lab work as well as arrange for missing pieces of telehealth equipment. Failure to coordinate patient care and services may result in poor patient outcomes. The patients affected are 1, 2, 3, and 4. Findings are:	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy L Bumgarner | TITLE: VP/COO | (X6) DATE: 2/8/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Visiting Nursing Association of WNY, Inc. - Provider 337006
PLAN OF CORRECTION
Complaint# NY 00078938

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

RESPONSE: The President of the Visiting Nursing Association of WNY, Inc. will direct the Director of Patient Services, the Director of Quality Assurance and the VNA Clinical managers in the following measures to respond to the Statement of Deficiencies.

Corrective actions accomplished for patients found to be affected by this deficiency: By 2/26/10
The Director of Patient Services and Clinical Managers will review the deficiencies with the clinicians involved with patients 1, 2, 3 and 4. The clinicians involved will be re-instructed that it is VNA policy to notify the physician of any vital sign values that are outside the parameters set by the physician. Also, any change in patient condition that may cause a change in the patient's treatment, must be promptly reported to the physician. All changes in the patient's condition must be reported to the case manager by a communication note in the clinical record. These records cannot be corrected retrospectively.

RESPONSE:

Other patients having the potential to be affected by this deficiency will be identified by: By 2/26/10
The Utilization Review committee will include a specific focus on case management and care coordination, specifically documented communication of any abnormal results to the case manager and physician (i.e. blood work) and also follow up when changes are reported from the clerical staff. All disciplines ordered are initiated within ten days from the start of care. Communication of lab work must be documented in the clinical record. Clinical records found to be deficient will be directed to the appropriate clinical manager for correction and counseling of staff if necessary.

Measures to ensure the deficiency does not recur: By 2/26/10
All clinical staff will be reeducated on the following VNA policies:
SVC 212 Case Management, SVC 213 Internal Referrals and SVC 235 Reporting to the Physician.

SVC 212, which states that all care providers will relay to the case manager information that is necessary for service integration. The case manager is responsible for coordinating care, all care providers are responsible to report changes to the physician. SVC 213 states each care provider must initiate the appropriate internal referrals based upon the needs of the patient. SVC 235 states the care providers should report any changes in the patient's condition that may warrant a change in the plan of care.

Corrective actions to be monitored to ensure the deficiency will not recur: Results of the Utilization Review committee record audits will be complied to identify trends and the need for further education. Results of the Utilization review Committee record audits will be presented to the Professional Advisory Committee (PAC) quarterly for review and recommendation. Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers. RESPONSIBLE PERSON: Lisa Greisler	Beginning March 2010 and each quarter thereafter

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

RESPONSE:	Corrective actions accomplished for patients found to be affected by this deficiency: Patients 1,2,4. A physician order will be obtained to correct the visit frequency. What about (1) #2 Coumadin order	By 2/26/10
	Other patients having the potential to be affected by the deficiency: The Utilization Review Committee will include a specific focus on 1) visit frequency matching ordered frequency on the plan of care or additional orders. 2) Interventions consistent with physician orders. Clinical records found to be deficient will be directed to the clinical manager for correction and counseling of staff if necessary.	Begin February 2010 and monthly
	Measures to ensure that the deficiency does not recur are: All clinical staff will be reeducated on the following VNA policies by the Director of Clinical services and Clinical Managers. SVC 216 VNA Plan of Care – that all clinicians must follow the physician established plan of care and address all interventions listed on the plan of care and additional orders. Clinical staff must follow the visit frequency established by the physician. A complete assessment of the patient must be completed at each visit.	By 2/26/2010
	Corrective actions to be monitored to ensure that the deficiency does not recur: Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education. Results of the UR committee record audits will be presented to quarterly to the PAC for review and recommendations. Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers. RESPONSIBLE PERSON: Lisa Greisler	Beginning March 2010 and each quarter thereafter

C. Recert date
2. orders for meds
3. BP 137 [illegible]
4. [illegible] weekly [illegible] monthly

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses,

including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

RESPONSE

Corrective actions accomplished for patients found to be affected by this deficiency: — By 2/26/10

Patient 1 – an order for Ensure and Tylenol will be obtained, the wound care orders will be clarified.
Patient 2 – the diet and miralax orders will be clarified.
Patient 3 – An order clarifying the frequency of the PT/INR lab work visit frequency and addition of ensure to the POC will be obtained. Also, the visit frequency will be clarified.

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review committee will include a specific focus on: — Beginning in February and each month thereafter

- All nutritional requirements are included on the plan of care (supplements and specific diet requirements)
- Medication profile includes all over the counter (OTC) medications.
- Visit frequency on the plan of care must be complete and individualized for the patient.
- Referral orders for assessment and evaluation by the disciplines are included on the POC.
- POC includes parameters for blood glucose monitoring.

Measures to ensure the deficiency does not recur are: — By 2/26/10
All clinical staff will be reeducated on the following VNA polices by the Director of Clinical Services and the clinical managers:
SVC 216 VNA Plan of Care which states that all clinicians must follow the physician established plan of care and address all interventions listed on the plan of care and additional orders. Clinical staff must follow the visit frequency established by the physician. A complete assessment of the patient must be completed at each visit and SVC 205 Initial Assessment/Reassessment which states a comprehensive assessment of the patient status and needs will be completed by the caregiver on the initial visit.

Corrective actions to be monitoring to ensure the deficiency will not recur: — Beginning March 2010 and each quarter thereafter
Results of the Utilization Review Committee record audit will be compiled to identify trends and the need for further education.

Results of the UR Committee record audits will be presented to the PAC quarterly for review and recommendations. Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON. Lisa Greisler

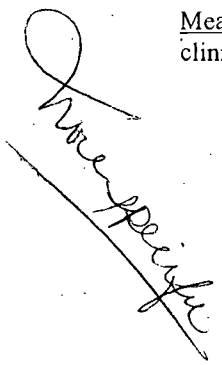
TAG	SUMMARY STATEMENT OF DEFICIENCIES
G164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case—mix assignment; or a discharge and return to the same HHA during the 60 day episode.

RESPONSE

Corrective actions accomplished for patients found to be affected by this deficiency: The clinical managers reviewed the deficiencies with the clinicians involved (Patients 1,2,3,4). The records cannot be corrected retrospectively. — By 2/26/2010

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the monthly clinical record review process, a focus on documentation of communication with the physician regarding changes in the client condition. — Begin February 2010 and each month

Clinical records reviewed and found to be deficient will be directed to the appropriate clinical manager for counseling as appropriate.



Measures to ensure the deficiency does not recur are: The Director of Service and clinical Managers will reinstruct the clinicians on the following VNA policies: — By 2/26/2010

- SVC 212 Case Management specifically that the case manager is responsible for assuring that the physician is notified regarding significant changes. It is the responsibility of each care provider to communicate to the physician information that may necessitate a change in the plan of care.
- SVC 235 Reporting to the Physician, specifically that it is the responsibility of all clinicians to promptly report to the physician any significant changes in the client's condition that may alter the plan of care.

Corrective actions to be monitoring to ensure the deficiency will not recur: Results of the Utilization Review Committee record audits will be compiled to identify trends and need for further education. — Beginning March 2010 and quarterly thereafter

Results of the Utilization Review Committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations from the PAC will be reviewed and implemented with the clinical managers and careproviders.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G166	484.18(C) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.

RESPONSE:

Corrective actions accomplished for patients found to be affected by this deficiency: — By 2/26/2010

The clinical managers will review the record with the clinician involved. Corrections, as appropriate, will be made to the record with the addition of a communication note.

Patient 1

- the medication dose will be clarified by physician order.
- The agency will obtain a physician's order for the breathing treatment.

Patient 2

- The agency will obtain a physician order for telehealth services including what was to be monitored, the frequency of monitoring and the parameters for each item monitored.

- The Coumadin dose will be clarified by physician order.
- The Tylenol dose will be clarified by physician order.

Patient 3

- The agency will obtain a physician order for the lab work performed 11/7/2009, including clarification of the frequency of the PT/INR.

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include a monthly audit a focus on providing care according to physician orders.
Clinical records found to be deficient will be forwarded to the clinician's manager for correction.

Beginning February 2010 and monthly

Measures to ensure the deficiency does not recur are:
The Director of Clinical Services will reinstruct the Clinical Managers and care providers in the following policies and procedures: Clinicians will be reeducated regarding "Conformance with Physician Orders" including policy and procedures., SVC 214, Conformance with Medical Orders", SVC 216 "Plan of Care", and SVC 235 Reporting to the Physician.

By 2/26/10

Corrective actions to be monitoring to ensure the deficiency will not recur:
Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education.

Beginning March 2010 and quarterly

Results of the Utilization Review committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G172	484.30(A) DUTIES OF THE REGISTERED NURSE The registered nurse regularly reevaluates the patients nursing needs.

RESPONSE:

Corrective actions accomplished for patients found to be affected by this deficiency:
The clinical managers reviewed the record with the clinician involved. No corrections can be made to the record of patients affected by this deficiency will review the deficiencies identified with the clinicians involved.

By 2/26/2010

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the monthly clinical record audit a specific focus on duties of the registered nurse including interventions completed as ordered by the physician and MD notified of changes in the patient condition.

Beginning February 2010 and monthly

Clinical records reviewed and found to be deficient will be directed to the clinical managers for correction and counseling of staff as needed.

Measures to ensure the deficiency does not recur are:
The Director of Clinical Services will reinstruct the clinical managers and careproviders in the following policies and procedures:

- Wound and Skin Care guidelines

By 2/26/2010

- Therapeutic Procedure 620 Medication Administration
- SVC 214 Conformance with Medical Orders
- SVC 216 Plan of Care
- SVC 205 Initial Assessment/Reassessment
- SVC 235 Reporting to the Physician.

A memo will be sent to staff regarding the need to demonstrate and assess re-demonstration of the glucose meter.

The telehealth policies and procedures will be updated to reflect the duties of the registered nurse and LPN in accordance with the scope of practice as defined in the NYS Nurse Practice Act.

Corrective actions to be monitoring to ensure the deficiency will not recur:
Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education.

Beginning March 2010 and quarterly thereafter

Results of the Utilization Review committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations for the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
J508	763.5(a)(1-2) Patient Referral and Admission 763.5 Patient Referral and Admission (a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless: (1) the patient's authorized practitioner orders otherwise; or (2) there is written documentation that the patient or family refuse such a visit.

RESPONSE

Corrective actions accomplished for patients found to be affected by this deficiency:
No corrections can be made to the records of patients found to be affected by this deficiency.

Other patients having the potential to be affected by this deficiency will be identified by: The clinical managers will audit 10 records each month for three months. The audit will focus on identifying patient's admission date compared to referral date and any documentation in the record substantiating a difference of more than 24 hours.

Beginning February 2010 and monthly for three months total

The Utilization Review Committee will include in the monthly clinical record review process a specific focus on admission date compared to referral date. Any charts that are deficient will be returned to the manager for correction.

Measures to ensure the deficiency does not recur are:
The Director of Patient Services will instruct the clinical managers and care provider in the following polices and procedures:

By 2/26/2010

- SVC 203 Request for Services
- SVC 205 Initial Assessment/Reassessment

Corrective actions to be monitoring to ensure the deficiency will not recur:

Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education.

Beginning March 2010 and quarterly thereafter

Results of the Utilization Review committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations for the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

Visiting Nursing Association of WNY, Inc. - Provider 337006
PLAN OF CORRECTION
Complaint# NY 00078938

The President of the Visiting Nursing Association of WNY, Inc. will direct the Director of Patient Services, the Director of Quality Assurance and the VNA Clinical managers in the following measures to respond to the Statement of Deficiencies. The Utilization Review Committee will audit 25 charts each month.

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

RESPONSE:

Corrective actions accomplished for patients found to be affected by this deficiency:
The Director of Patient Services and Clinical Managers will review the deficiencies with the clinicians involved with patients 1, 2, 3 and 4. The clinicians involved will be re-instructed that it is VNA policy to notify the physician of any vital sign values that are outside the parameters set by the physician. Also, any change in patient condition that may cause a change in the patient's treatment, must be promptly reported to the physician. All changes in the patient's condition must be reported to the case manager by a communication note in the clinical record. These records cannot be corrected retrospectively. By 2/26/10

RESPONSE:

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review committee will include a specific focus on case management and care coordination, specifically documented communication of any abnormal results to the case manager and physician (i.e. blood work) and also follow up when changes are reported from the clerical staff. All disciplines ordered are initiated within ten days from the start of care. Communication of lab work must be documented in the clinical record. Clinical records found to be deficient will be directed to the appropriate clinical manager for correction and counseling of staff if necessary. By 2/26/10

Measures to ensure the deficiency does not recur: By 2/26/10
All clinical staff will be reeducated on the following VNA policies:
SVC 212 Case Management, SVC 213 Internal Referrals and SVC 235 Reporting to the Physician.

SVC 212, which states that all care providers will relay to the case manager information that is necessary for service integration. The case manager is responsible for coordinating care, all care providers are responsible to report changes to the physician. SVC 213 states each care provider must initiate the appropriate internal referrals based upon the needs of the patient. SVC 235 states the care providers should report any changes in the patient's condition that may warrant a change in the plan of care.

	Corrective actions to be monitored to ensure the deficiency will not recur: Results of the Utilization Review committee record audits will be complied to identify trends and the need for further education.	Beginning March 2010 and each quarter thereafter
	Results of the Utilization review Committee record audits will be presented to the Professional Advisory Committee (PAC) quarterly for review and recommendation.	
	Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers.	
	RESPONSIBLE PERSON: Lisa Greisler	

TAG	SUMMARY STATEMENT OF DEFICIENCIES	
G158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	
RESPONSE:	Corrective actions accomplished for patients found to be affected by this deficiency: Patients 1,2,4. A physician order will be obtained to correct the visit frequency.	By 2/26/10
	Other patients having the potential to be affected by the deficiency: The Utilization Review Committee will include a specific focus on 1) visit frequency matching ordered frequency on the plan of care or additional orders. 2) Interventions consistent with physician orders. Clinical records found to be deficient will be directed to the clinical manager for correction and counseling of staff if necessary, 3) documentation of teaching done during visits including what was taught, to whom and level of understanding demonstrated, 4) teaching completed as ordered on the plan of care, and 5) physician notified of changes outside of parameters and significant changes.	Begin February 2010 and monthly
	Measures to ensure that the deficiency does not recur are: All clinical staff will be reeducated on the following VNA policies by the Director of Clinical services and Clinical Managers.	By 2/26/2010
	SVC 216 VNA Plan of Care – that all clinicians must follow the physician established plan of care and address all interventions listed on the plan of care and additional orders. Clinical staff must follow the visit frequency established by the physician. A complete assessment of the patient must be documented at each visit.	
	SVC 214 Conformance with Medical Orders – all services shall be provided in accordance with the physician orders, any problems or adverse reaction or side effects of medications shall be reported to the physician.	
	Procedure 010 Guidelines for Documentation on the Nursing Clinical Note – a skilled assessment be completed at each visit, vital signs must be completed at each visit;	

Corrective actions to be monitored to ensure that the deficiency does not recur:
Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education. — Beginning March 2010 and each quarter thereafter

Results of the UR committee record audits will be presented to quarterly to the PAC for review and recommendations. Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

RESPONSE

Corrective actions accomplished for patients found to be affected by this deficiency: — By 2/26/10
Patient 1 – an order for Ensure and Tylenol will be obtained, the wound care orders will be clarified.
Patient 2 – the diet and miralax orders will be clarified.
Patient 3 – An order clarifying the frequency of the PT/INR lab work visit frequency and addition of ensure to the POC will be obtained. Also, the visit frequency will be clarified.

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review committee will include a specific focus on: — Beginning in February and each month thereafter

- All nutritional requirements are included on the plan of care (supplements and specific diet requirements)
- Medication profile includes all over the counter (OTC) medications.
- Visit frequency on the plan of care must be complete and individualized for the patient.
- Referral orders for assessment and evaluation by the disciplines are included on the POC.
- POC includes parameters for blood glucose monitoring.

Measures to ensure the deficiency does not recur are: — By 2/26/10
All clinical staff will be reeducated on the following VNA polices by the Director of Clinical Services and the clinical managers:
SVC 216 VNA Plan of Care which states that all clinicians must follow the physician established plan of care and address all interventions listed on the plan of care and additional orders. Clinical staff must follow the visit frequency established by the physician. A complete assessment of the patient must be completed at each visit and SVC 205 Initial Assessment/Reassessment which states a comprehensive assessment of the patient status and needs will be completed by the caregiver on the initial visit.

Corrective actions to be monitoring to ensure the deficiency will not recur:
Results of the Utilization Review Committee record audit will be compiled to identify trends and the need for further education. — Beginning March 2010 and each quarter thereafter

Results of the UR Committee record audits will be presented to the PAC quarterly for review and recommendations. Recommendations from the PAC will be

reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON. Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case—mix assignment; or a discharge and return to the same HHA during the 60 day episode.

RESPONSE

Corrective actions accomplished for patients found to be affected by this deficiency: The clinical managers reviewed the deficiencies with the clinicians involved (Patients 1,2,3,4). The records cannot be corrected retrospectively. — By 2/26/2010

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the monthly clinical record review process, a focus on documentation of communication with the physician regarding changes in the client condition. — Begin February 2010 and each month

Clinical records reviewed and found to be deficient will be directed to the appropriate clinical manager for counseling as appropriate.

Measures to ensure the deficiency does not recur are: The Director of Service and clinical Managers will reinstruct the clinicians on the following VNA policies: — By 2/26/2010

- SVC 212 Case Management specifically that the case manager is responsible for assuring that the physician is notified regarding significant changes in the patient's condition.
- SVC 235 Reporting to the Physician. It is the responsibility of all clinicians to promptly report to the physician any changes in the client's condition they discover that necessitate a change in the plan of care. All communication to the physician must be documented in the record.

Corrective actions to be monitoring to ensure the deficiency will not recur: Results of the Utilization Review Committee record audits will be compiled to identify trends and need for further education. — Beginning March 2010 and quarterly thereafter

Results of the Utilization Review Committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations from the PAC will be reviewed and implemented with the clinical managers and careproviders.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G166	484.18(C) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.

RESPONSE: Corrective actions accomplished for patients found to be affected by this deficiency: By 2/26/2010

The clinical managers will review the record with the clinician involved. Corrections, as appropriate, will be made to the record with the addition of a communication note.

Patient 1

- the medication dose will be clarified by physician order.
- The agency will obtain a physician's order for the breathing treatment.

Patient 2

- The agency will obtain a physician order for telehealth services including what was to be monitored, the frequency of monitoring and the parameters for each item monitored.
- The Coumadin dose will be clarified by physician order.
- The Tylenol dose will be clarified by physician order.

Patient 3

- The agency will obtain a physician order for the lab work performed 11/7/2009, including clarification of the frequency of the PT/INR.

Patient 4

- The agency will obtain an order to clarify the nursing frequency. The agency will obtain and order for the Colace.

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include a monthly audit a focus on providing care according to physician orders. Beginning February 2010 and monthly
Clinical records found to be deficient will be forwarded to the clinician's manager for correction.

Measures to ensure the deficiency does not recur are: By 2/26/10
The Director of Clinical Services will reinstruct the Clinical Managers and care providers in the following policies and procedures: Clinicians will be reeducated regarding "Conformance with Physician Orders" including policy and procedures., SVC 214, Conformance with Medical Orders", SVC 216 "Plan of Care", and SVC 235 Reporting to the Physician.

Corrective actions to be monitoring to ensure the deficiency will not recur: Beginning March 2010 and quarterly
Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education.

Results of the Utilization Review committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations from the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G172	484.30(A) DUTIES OF THE REGISTERED NURSE The registered nurse regularly reevaluates the patients nursing needs.

RESPONSE: Corrective actions accomplished for patients found to be affected by this deficiency: By 2/26/2010

The clinical managers will review the record with the clinicians involved. No corrections can be made to the record of the patients affected by this deficiency.

Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the monthly clinical record audit a specific focus on duties of the registered nurse including interventions completed as ordered by the physician and MD notified of changes in the patient condition. — Beginning February 2010 and monthly

Clinical records reviewed and found to be deficient will be directed to the clinical managers for correction and counseling of staff as needed.

Measures to ensure the deficiency does not recur are:
The Director of Clinical Services will reinstruct the clinical managers and careproviders in the following policies and procedures: — By 2/26/2010

- Wound and Skin Care guidelines
- Therapeutic Procedure 620 Medication Administration
- SVC 214 Conformance with Medical Orders
- SVC 216 Plan of Care
- SVC 205 Initial Assessment/Reassessment
- SVC 235 Reporting to the Physician.

A memo will be sent to staff regarding the need to demonstrate and assess re-demonstration of the glucose meter.

The telehealth policies and procedures will be updated to reflect the duties of the registered nurse and LPN in accordance with the scope of practice as defined in the NYS Nurse Practice Act.

Corrective actions to be monitoring to ensure the deficiency will not recur:
Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education. — Beginning March 2010 and quarterly thereafter

Results of the Utilization Review committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations for the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

TAG	SUMMARY STATEMENT OF DEFICIENCIES
J508	763.5(a)(1-2) Patient Referral and Admission 763.5 Patient Referral and Admission (a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless: (1) the patient's authorized practitioner orders otherwise; or (2) there is written documentation that the patient or family refuse such a visit.
RESPONSE	Corrective actions accomplished for patients found to be affected by this deficiency: No corrections can be made to the records of patients found to be affected by this deficiency.

Other patients having the potential to be affected by this deficiency will be identified by: The clinical managers will audit 10 records each month for three months. The audit will focus on the patient's admission date compared to referral — Beginning February 2010 and monthly

date. If the SOC assessment is not completed within 24 hours, the record must contain documentation substantiating the reason. for three months total

The Utilization Review Committee will also include in the monthly clinical record review this same focus as mentioned above. Any charts that are deficient will be returned to the manager for correction.

Measures to ensure the deficiency does not recur are: By 2/26/2010
The Director of Patient Services will instruct the clinical managers and care provider in the following polices and procedures:

- SVC 203 Request for Services
- SVC 205 Initial Assessment/Reassessment – specifically that the SOC assessment must be completed within 24 hours from receipt and acceptance of the referral or return from institutional placement, unless there is written documentation that the patient/family refuses, the physician orders otherwise, or there is written documentation of unsuccessful attempts to contact the patient/family, the assessment should be completed within 24 hours.

Corrective actions to be monitoring to ensure the deficiency will not recur:
Results of the Utilization Review Committee record audits will be compiled to identify trends and the need for further education. Beginning March 2010 and quarterly thereafter

Results of the Utilization Review committee record audits will be presented to the PAC quarterly for review and recommendations.

Recommendations for the PAC will be reviewed and implemented with the clinical managers and care providers.

RESPONSIBLE PERSON: Lisa Greisler

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337006	A. BUILDING _____ B. WING _____	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA OF WESTERN NY CHHA	2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies is the result of a complaint investigation #NY00070821 conducted by staff of the Western Regional Office of the New York State Department of Health on 4/20/09. During this investigation three (3) clinical records were reviewed.	G 000	Corrective action accomplished for patients found to be affected by this deficiency: The clinical manager/branch manager will review the deficiencies identified with the clinicians involved. Corrections, as appropriate, will be made to the clinical record by addition of communication note.	10/16/09
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on review of one (1) of three (3) clinical records and interview of agency staff, it was determined that staff did not maintain adequate liaison to ensure support of patient care. The issues included lack of communication between the agency services (Southern Tier Home Care, Inc and Visiting Nurse Service of Western New York) assigned to provide patient care. The failure to provide coordination of services has the potential to impact negatively on patient care. The affected patient is 1. The finding is: Patient 1 - This [redacted] year-old patient with diagnoses of decubitus occipital scalp and quadriplegia was admitted to the agency on 4/2/09. The clinical record included a referral by the physician for wound care to the scalp. The patient had 24/7 nursing care provided by a different home care agency.	G 143	Patient 1 – Finding # 1 The clinician was instructed that the CHHA nurse is responsible to coordinate all services provided to the patient by our agency and by other community agencies. The CHHA survey staff must promptly communicate any care plan revisions to the LHHCA staff. This communication must be documented in the CHHA clinical record. Finding #2 The clinician was instructed to document all conversations with other agency staff to ensure the patient receives the ordered care and services. Finding # 3 & # 4 The clinician was instructed to document all clinical findings and concerns in the chart record promptly. Also, must be communicated to other community agencies involved with the patients care. Other patients having the potential to be affected will be identified by: The Utilization Review Committee will include a specific focus on care coordination with other providers and follow up when changes are reported from staff. Clinical records found to be deficient will be returned to the clinical manager for correction and staff counseling as needed.	10/16/09 10/16/09 Beginning Oct 2009 and monthly thereafter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy L Bourgeois — TITLE: Vice President — (X6) DATE: 10/13/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337006	A. BUILDING _____ B. WING _____	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA OF WESTERN NY CHHA	2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 1 The skilled nursing initial visit for OASIS assessment of 4/2/09 documented that teaching was done to "keep pressure off back of her head using rolled towel under base of her neck, and small pillow at the top of her head." Treatments included "assessment, wound measurements taken and photos taken". There is no documented evidence in the patient record that this information was communicated to the nursing staff caring for the patient. There was no documented evidence that communication occurred to facilitate the patient's care plan revision to include the positioning taught at the initial visit. A physical therapy note of 4/20/09 included patient will be provided with head support to allow occipital ulcer to heal. There is no documentation evident that nursing and physical therapy communicated or coordinated the care for facilitation of the head support. On 4/7/09 skilled nursing documented in the case communication report that she observed the patient being turned quickly, bounced with turning and that there was a noise. The nurse documented that the caregiver made inappropriate comments about the patient and that turning the patient caused the dressing at the back of the head to be " ripped off " and frank bleeding was observed and that the dressing was not applied until the patient was up in a chair. There was no documentation in the clinical record that this concern was communicated to the nursing supervisors of the agencies involved or coordination occurring involving specific actions to take to prevent the immediate reoccurrence of inappropriate comments or incorrect turning and positioning.	G 143	Measures to ensure the deficiency does not recur: The Director of Patient Services will re-instruct the clinical managers/branch managers and clinicians in the following policies and procedures: Clinicians will be re-educated regarding VNA policy SVC 212 Care Management, SVC 216 Plan of Care and Procedure # 10 Guidelines for Documentation in the Clinical Note by Voice Mail and Memo. Specifically, that the CHHA is responsible to manage coordinate services provided by other community agencies include LHHCA. Corrective actions to be monitored to ensure the deficiency does not recur: Instructed to communicate all changes in patient care to the care providers as soon as orders are received. Results of the Utilization Review Committee record audits and action plans will be presented to the Quality Assurance/Performance Improvement Committee and Professional Advisory Committee quarterly for review and recommendation. Recommendations from the Professional Advisory Committee will be reviewed and implemented with the clinical managers/branch managers and staff. Responsible person: Director of Patient Services	10/16/09 Beginning Nov 2009 and quarterly thereafter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337006	A. BUILDING _____ B. WING _____	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA OF WESTERN NY CHHA	2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 2 On 4/10/09 a wound specialist assessed the patient and documented recommendations that included " nurses to establish and reinforce a turning and positioning schedule with patient and caregivers. A 30-degree lateral position while in bed is optimal. This will not allow pressure directly on the back of the head. This can be done while in bed and chair around the clock as the back of head needs to be protected while up in the chair also " . There is no documented evidence in the patient record that communication to the care providers occurred regarding this recommendation or when the recommendation was followed. Interview with the CHHA (community home health nurse) on 4/20/09 included that she called the supervisor of the agency involved, expressed her concerns but did not document this conversation and that there was no further follow up to the issues identified. Interview with Director of Patient Services on 4/20/09 included she was aware of the issues but there was no documentation in the patient clinical record and that this agency is " only in the home due to a physician referral for wound care recommendations. " No further information was provided.	G 143	484.1(8b) The clinical managers will review the deficiencies identified with the involved clinicians. Corrective actions accomplished for patients found to be affected by this deficiency: Patient 1 – The clinician was reinstructed on the importance of following the plan of care as ordered and notifying the physician of signs and symptoms of non-healing, and any changes in the patient's condition that may warrant a change in the plan of care. Other patients having the potential to be affected will be identified by: The Utilization Review Committee record audits will include a specific focus on documentation of physician notification of changes in the client's condition. Clinical records found to be deficient will be returned to the clinical manager for correction and staff counseling as needed. Measures to ensure the deficiency does not recur: The Director of Patient Services will reeducate the clinical managers/branch managers and clinicians in the following policies and procedures: SVC 235 Reporting to the Physician and SVC 214 Conformance with Medical Orders. Corrective actions to be monitored to ensure the deficiency does not recur: Results of the Utilization Review committee record review audits will be presented to the Quality Assurance/Process Improvement Committee and Professional Advisory Committee quarterly for review and recommendation. Recommendations from the Professional Advisory Committee will be reviewed and implemented with the clinical managers/branch managers and staff. The Quality Assurance Performance Improvement Committee will monitor the results of the clinical record review for compliance with the plan of correction. Responsible person: Director of Patient Services	10/16/09 Beginning Oct 2009 and monthly thereafter Beginning Nov 2009 and quarterly thereafter
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by:	G 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337006	A. BUILDING _____ B. WING _____	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA OF WESTERN NY CHHA	2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221

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G 164	Continued From page 3 Based on clinical record review, agency policy and procedure review and interview with agency staff in one (1) of three (3) clinical records, agency staff failed to notify the physician of changes in patient condition that may have resulted in a change to the plan of care. The issues are failure to notify the physician for changes in wound condition. There is potential for complications to the patient to arise by not alerting the physician. This affected patient 1. The finding is: Patient 1 - This [redacted] year-old patient with diagnoses of occipital scalp wound and [redacted] was admitted to the agency on 4/2/09. The clinical record for the skilled nursing initial oasis assessment completed on 4/2/09 included that the patient had a staqe 2 pressure ulcer to the back of the head with purulent yellow and tan drainage. On 4/13/09 skilled nursing documented a large amount of purulent thick, green drainage that saturated the dressing. The skilled nursing communication note on 4/13/09 included that the care provider moved the patient so that the dressing was torn off the occipital scalp area and there was frank bleeding. The Plan of Care (POC) from 4/2/09 to 5/31/09 included to notify the physician of signs and symptoms of non-healing. There is no documentation in the clinical record that the physician was notified regarding the change in wound drainage. Interview with the Director of Patient Services on 4/20/09 provided no further information.	G 164	484.30(a) Corrective Actions accomplished for patients found to be affected by this deficiency: The Clinical Manager will review the deficiency identified with the involved clinicians. Finding # 1 The clinician was reinstructed to include a complete set of vital signs at each visit as ordered on the plan of care. Finding # 2 & #3 Exit The clinician was reinstructed to complete and include in her documentation a complete skin assessment. Also, to notify the physician of any changes in the patient's condition that could warrant a change in the plan of care. All changes in the patient condition must be documented in the visit note. A case communication note was added to clarify the visit observation of 4/7/09 and 4/13/09. Other patients having the potential to be affected will be identified by: The Utilization Review Committee record audit will include in the monthly record a review of the visit note and that it contains a complete set of vital signs and skin assessments. Also, that all changes in the patient condition are communicated to the physician. Clinical records found to be deficient will be returned to the clinical manager for correction and staff counseling as needed. Measures to ensure the deficiency does not recur are: The Director of Patient Services will reinstruct the clinical managers/branch managers and care providers in the following policies and procedures: Conformance with the Physician Orders, SVC 235 Reporting to the Physician (changes that may necessitate a change in the plan of care). VNA policy and procedure # 10 Guidelines for Documentation in the Clinical Note, VNA Policy SVC 214	10/16/09 10/16/09 10/16/09 Beginning Oct 2009 and monthly thereafter 10/16/09
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the	G 172		

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	337006	A. BUILDING _____ B. WING _____	C 04/20/2009

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G 172	Continued From page 4 patients nursing needs. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy and procedure and interview with agency staff, evidence is lacking in one (1) of three (3) clinical records that the registered nurse regularly re-evaluated the patient's needs. This is evidenced by failure to provide comprehensive assessment of the patient. The failure to regularly evaluate the patient's needs places the patient at risk for poor outcomes of care and potential unmet needs. This affected patient 1. The finding is: Patient 1 - This [redacted] year-old patient with diagnoses of occipital head wound and [redacted] was admitted to the agency on 4/2/09. The patient was referred by the physician for wound care recommendations and consultation and was currently being provided with twenty-four hour nursing care by the another home care agency. The consulting agency plan of care for 4/2/09 to 5/31/09 directed CHHA nursing to obtain vital signs weekly. A skilled nursing visit on 4/7/09 did not include vital signs as being taken and recorded that wound care was reviewed with LPN (licensed practical nurse) "no change in patient condition since last visit". The patient record reviewed at the agency providing the twenty-four hour nursing care included documentation that the patient had open areas on the abdominal fold on 4/8 and 4/9/09. On 4/11/09, the care providers identified a small open area in the patient's left groin. The next	G 172	Corrective actions to be monitored to ensure the deficiency does not recur: Results of the Utilization Review committee record review audits will be presented to the Quality Assurance/Process Improvement Committee and Professional Advisory Committee quarterly for review and recommendations. Recommendations from the Professional Advisory Committee will be reviewed and implemented with the clinical managers/branch managers and staff. The Quality Assurance Performance Improvement Committee will monitor the results of the clinical record review for compliance with the plan of correction. Responsible person: Director of Patient Services Accepted 10/13/09	Beginning Nov 2009 and quarterly thereafter

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G 172	Continued From page 5 skilled nursing visit on 4/13/09 included documentation "that there was no change in the patient's condition" although the nurse stated "large amount of drainage as purulent thick green and foul" .However, the nursing documentation on 4/7/09 included that the drainage was tan/brown. The agency providing the 24/7 care identified that the patient right ankle was red on 4/7/09 and that the patient had swelling with warmth of the right arm and pain on movement with bruising noted on 4/9/09 that continued through 4/22/09. The agency CHHA (community home health agency) nurse did not identify any of these concerns although documented visits of 4/2, 4/7 and 4/13/09 included assessments as being completed. The skilled nursing visit of 4/13/09 identified "ecchymosis right ac yellowish tone noted to skin old bruise". The agency providing the 24/7 care documented in the patient record that on 4/13/09 the " outer aspect of right elbow remains warm to touch and swollen. Felt grinding with supination and pronation". VNA here today". There was no documentation in the CHHA skilled nursing assessment notes regarding these issues although the nurse documented an observed bruise. The undated agency policy titled WOUND DOCUMENTATION GUIDELINES included "don't forget about prevention.- skin assessments at SOC and every visit subsequent visit must include a thorough skin assessment. Have the patient remove their shoes and socks so you can check their feet for pressure areas, maceration ect. Check the buttocks for open areas or redness. Look at back hips and elbows. Check	G 172		

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G 172	Continued From page 6 skin folds. Our patients count on us to find potential problems before they turn into real issues for them". Interview with the Director of Patient Services on 4/20/09 provided no additional information but stated the agency nurse was in the patient home due to physician referral for wound care consultation.	G 172		

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G 000	INITIAL COMMENTS This statement of deficiencies is a result of a complaint investigation (CO#NY00069438) conducted by the staff of the Western Regional Office of the New York State Department of Health on 3/10/09. Three (3) clinical records were reviewed.	G 000		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on clinical record review and interview with agency staff, three (3) of the three (3) clinical records lacked evidence that care did follow the order established by the physician. The issues are following orders for the nurse to observe patient self-injection of insulin and glucometer use. The failure to follow physician's orders has the potential to result in provision of care outside of the physician's prescribed plan, which may have adverse outcomes. Patients affected are A, B and C. Findings are: Patient A - This [redacted]year-old patient with diagnosis of gestational diabetes was admitted to the agency on 1/3/09. The certification and plan of care (POC) dated 1/3/09 - 3/3/09 ordered the nurse to visit once with two (2) as needed visits. The nurse was ordered to perform physical and antepartum assessments, provide prenatal education, teach signs and symptoms of complications, medications - proper use, rationale side effects, standard precautions, 2200 calorie	G 165		

Accepted
4.1.09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy L Saunders | TITLE: VP | (X6) DATE: 4/6/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 165	Continued From page 1 ADA (American Diabetic Association) diet, glucometer use and recording blood sugars in a log. The physician referral dated 12/31/08 specifically ordered then nurse to provide "gestational diabetes education (nursing assessment, education, demonstration of glucometer, etc.).." On the 1/3/09 start of care (SOC) visit, the nurse documented teaching on glucometer use, blood glucose monitoring, and the ADA diet. The nurse documented the patient's response to the teaching as "patient/caregiver verbalizes understanding of all teaching items listed above." There is no documented evidence the patient demonstrated use of the glucometer. An interim physician order dated 1/13/09 directed the nurse to visit the patient to provide instruction on newly prescribed insulin - "Humulin N 5 units subcutaneously at 8 PM". When contacted by the agency on 1/13/09, the patient had not yet obtained the medication or supplies, so a visit was scheduled for 3 PM on 1/14/09. According to the Medication Profile in the record, the patient had not had insulin prescribed in the past. There is no documentation that the patient or husband had experience with the administration of injectable medications. The nurse documented on 1/14/09 "Teaching done regarding insulin administration, patient and husband taught, verbalized good understanding , observed patient draw up five (5) units Humulin N without difficulty. Husband to administer sq (subcutaneous) injection at hours of sleep tonight, review of preferred sites." Evidence is lacking the nurse observed a demonstration of the injection technique". Patient C - This [redacted] year-old patient with diagnosis	G 165		

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G 165	Continued From page 2 of gestational diabetes was admitted to the agency on 12/23/08. The Certification and plan of care (POC) dated 12/23/08 - 2/22/09 ordered the nurse to visit once with two as need visits. The n nurse was ordered to perform physical and antepartum assessments, provide prenatal education, teach signs and symptoms of complications, medications - proper use, rationale side effects, standard precautions, 2200 calorie ADA (American Diabetic Association) diet, glucometer use and recording blood sugars in a log. The physician referral dated 12/18/08 specifically ordered then nurse to provide "gestational diabetes education (nursing assessment, education, demonstration of glucometer, etc.).." On the 12/23/08 start of care (SOC) visit, the nurse documented teaching on glucometer use, blood glucose monitoring, the ADA diet and signs and symptoms to report. The nurse documented the patient's response to the teaching as "patient/caregiver verbalizes understanding of all teaching items listed above." There is no documented evidence the patient demonstrated use of the glucometer. Patient B - This year-old patient with diagnoses of gestational diabetes was admitted to the agency on 11/9/08. On 11/19/08, the agency received an order to "observe self-injection of insulin, note blood glucose results." Upon review of the clinical record, the first nursing visit to the patient following receipt of this order was made on 11/22/08. According to the nursing visit note on that date, the nurse documented the following: "FBS 95 this AM; blood glucose levels 2 hours after pc (after meals) between 67 and 117. Skilled instruction/teaching given to (specify) patient, medication, rationale, side effects of: withdrawal and administration of insulin; signs and symptoms	G 165		

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G 165	Continued From page 3 of infection; diet: 22 calories ADA; when to call MD (physician): any changes or concerns. Response to instruction: verbalizing understanding". There is no documentation the nurse observed the patient self-inject the insulin. Interview was conducted regarding the above findings with the Director of Patient Services (DPS) and Director of Quality Assurance (DQA) on 3/10/09. The DPS stated the practice of the agency is to have the patient redemonstrate procedures such as glucometer use and self-injection of the insulin. The DQA contacted the nurse who provided the visit to Patient B. The DQA reported the nurse stated she had observed the patient appropriately prepare and administer the insulin. The DQA stated she had also tried to interview the nurse who had made the visit to Patient A, however, the nurse was not at work so it could not be confirmed that the nurse had observed the patient redemonstrate glucometer use.	G 165		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on clinical record review, agency policy	G 236		

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G 236	Continued From page 4 and procedure, and agency staff interviews, it was determined that three (3) of three 93) records reviewed, the agency did not maintain clinical records containing accurate and appropriate information. The issue is the agency staff did not follow the agency's policy for timely completion of discharge documentation. Failure of the agency to ensure complete. accurate and current documentation has the potential for agency clinicians and supervisors to make incorrect decisions based on lack of information that may result in negative patient outcomes. Patients affected are A, B and C. Findings are: Patient A - This [redacted] year-old patient with diagnosis of gestational diabetes was admitted to the agency on 1/3/09. On the patient roster provided to the surveyor on 3/11/09, the patient was listed as an "open case". Upon review of the clinical record, a physician signed Certification and plan of care for 1/3/09 - 3/3/09 was present. However, the clinical record lacked documented evidence of physician recertification of the patient's plan of care beginning 3/4/09. It also lacked evidence the patient had been discharged from the home care agency. Patient C - This [redacted] year-old patient with diagnosis of gestational diabetes was admitted to the agency on 12/23/08. On the patient roster provided to the surveyor on 3/11/09, the patient was listed as an "open case". Upon review of the clinical record, a physician signed Certification and plan of care for 12/23/08 - 2/22/09 was present. However, the clinical record lacked documented evidence of physician recertification of the patient's plan of care beginning 2/23/09. It	G 236		

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G 236	Continued From page 5 also lacked evidence the patient had been discharged from the home care agency. Interview was conducted regarding the above findings with the Director of Patient Serves (DPS) and Director of Quality Assurance (DQA) on 3/10/09. When asked about the current status of these cases, the DPS stated that the patients were discharged but the nurses has not completed the required discharge information. Review of Agency Policy #SVC 224 titled, " Discharge of Patient" with effective date of 11/30/06 states, "G. The decision to discharge patients will be based upon the following circumstances: 6. The patients' physician did not renew orders for patient care through the agency" and "L. The clinical record must be completed with all appropriate discharge documentation (discharge/transfer report and instructions, discharge clinical note/DAR) in accordance with agency procedures but not later than 48 hours after the last patient visit." The DPS confirmed the nurses did not follow the agency policy related to discharge documentation. Patient B - This [redacted] year-old patient with diagnosis of gestational diabetes was admitted to the agency on 11/9/08. The agency patient roster of gestational diabetes patients admitted between 11/08 - 3/09 presented to the surveyor on 3/11/09 listed this patient as a "closed" case on 11/22/08. According to the Clinical Summary to the physician on the 11/9/08 Certification and plan of care, the nurse documented "McAuley Seton contacting VNA stating they have case open with the patient. McAuley Seton to continue is visits with the patient. VNA will discharge." In the Case Communication Report dated 11/10/08, the nurse documented "message left for Margie RN (nurse	G 236		

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G 236	Continued From page 6 at physician's office) that McAuley Seton is placed in the home and they will continue to follow patient." Interview was conducted regarding the above findings with the Director of Patient Serves (DPS) and Director of Quality Assurance (DQA) on 3/10/09. The DPS stated that the clinical manager had documented in a Case Communication Report note on 11/21/08 that the case had been discharged in error. Since the agency's policy discharge criteria had been met, no explanation was provided why the manager made this decision.	G 236		

New York State Department of Health

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J 000	Initial Comments This statement of deficiencies is a result of a complaint investigation (CO#NY00069438) conducted by the staff of the Western Regional Office of the New York State Department of Health on 3/10/09. Three (3) clinical records were reviewed.	J 000		
J 508	763.5(a)(1-2) Patient Referral and Admission 763.5 Patient Referral and Admission. (a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless: (1) the patient's authorized practitioner orders otherwise; or (2) there is written documentation that the patient or family refuses such a visit. This Regulation is not met as evidenced by: Based on clinical record review and interview with agency staff, the agency failed in three (3) of three (3) clinical records to ensure that care was initiated within 24 hours of acceptance of the referral. There is the potential for development of unrecognized complications prior to admission to the home care agency putting the patients's health and welfare at risk. Patients affected as A, B and C. The findings are:	J 508		

Accepted 4/7/09

Office of Health Systems Management / Office of Long Term Care

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: VP — (X6) DATE: 4/6/09

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J 508	Continued From page 1 Patient A - This [redacted] year-old patient with diagnosis of gestational diabetes was admitted to the agency on 1/3/09. The patient was referred to the certified home care agency on 12/31/08. The referral included physician orders for the nurse to provider "gestational diabetes education (nursing assessment, education, demonstration of glucometer, etc.).." According to the clinical record, the first contact and visit with the patient was made on 1/3/09. There is no documentation in the clinical record the physician authorized or the patient refused a visit by the home care agency within 24 hours of the referral. Patient C - This [redacted] year-old patient with diagnosis of gestational diabetes was admitted to the agency on 12/23/08. The patient was referred to the certified home care agency on 12/18/08. The referral included physician orders for the nurse to provider "gestational diabetes education (nursing assessment, education, demonstration of glucometer, etc.).." According to the Case Communication Report, the first patient contact was made by telephone on 12/22/08 to set-up a visit. The first visit was made to initiate service on 12/23/08 at 8 AM. There is no documentation in the clinical record the physician authorized or the patient refused a visit by the home care agency within 24 hours of the referral. Interview with the Director of Patient Services and Director of Quality Assurance on 3/10/09 offered no additional information on these findings. Patient B - This [redacted] year-old patient with diagnosis of gestational diabetes was admitted to the agency on 11/9/08. According to the Clinical Summary to the physician on 11/9/08 Certification and plan of care, the nurse documented	J 508		

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VNA OF WESTERN NY CHHA	2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 508	Continued From page 2 "McAuley Seton to contacting VNA stating they have case open with patient. McAuley Seton to continue visits with patient. VNA will discharge." In the Case Communication Report dated 11/10/08, the nurse documented "message left for Margie RN (nurse at physician's office) that McAuley Seton is placed in the home and they will continue to follow patient." On 11/19/08 the patient was referred again to the certified home health agency by the physician's office. The referral included physician orders for the nurse to "observe self-injection of insulin, note blood glucose results." A Case Communication Note by the clinical manager dated 11/21/08 stated the patient's "previous episode (case number) discharged in error. Patient to continue to be seen under that episode." According to the clinical record, the first contact and visit with the patient was made on 11/22/08. There is no documentation in the clinical record the physician authorized or the patient refused a visit by the home care agency within 24 hours of the referral. Interview conducted with the Director of Patient Services and Director of Quality Assurance on 3/10/09. The Director of Patient Services stated that the Clinical Manager had documented on 11/21/08 that the case had not been discharged, so the referral was viewed as a continuation order. No further information was provided for the delay in initiation of service to the patient.	J 508		

Visiting Nursing Association of WNY, Inc. - Provider 337006
PLAN OF CORRECTION

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff as ordered by the physician.

RESPONSE: The President of the Visiting Nursing Association of WNY, Inc. will direct the Director of Patient Services, the Director of Quality Assurance and the VNA Clinical managers in the following measures to respond to the Statement of Deficiencies.

The Director of Patient Services will review the Statement of Deficiencies and Plan of Correction with the managers at the Clinical managers meeting in March 19, 2009. — 3/19/09

RESPONSE:	CORRECTIVE ACTIONS ACCOMPLISHED FOR PATIENTS FOUND TO BE AFFECTED BY THIS DEFICIENCY	COMPLETION DATE
RESPONSE:	The Director of Patient Service and clinical managers reviewed the deficiencies identified with the involved clinicians. (Patients A, B, C) The clinicians were instructed that it is VNA policy to provide care to the patient as ordered by the physician. Also, all care provided must be documented in the clinical record. Corrections, as appropriate, will be added to the clinical record of Patient B by addition of a communication note.	By 3/31/09
	Patient A; B, C The clinicians involved were re-educated on the importance of following the Plan of Care established by the physician and that all interventions listed on the Plan of Care must be addressed. Any instruction provided must be recorded. Observation of patient correct demonstrating use of equipment or procedures (such as use of a glucometer injection technique) must be documented in the clinical record.	3/31/09
	Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the clinical audit a focus on providing patient care as ordered by the physician. All instruction and assessment ordered by the physician must be completed and documented in the clinical record. Clinical records found to be deficient will be returned to the clinical manager for correction and staff counseling as needed.	Beginning in April and quarterly thereafter
	Measures to ensure the deficiency does not recur are: The Director of Patient Services will instruct the clinical managers and careproviders in the following policies and procedures: • VNA policy SVC 214 "Conformance with Medical Orders" and VNA policy 216 "VNA Plan of Care". The Director of Patient Services will review these policies by voice mail and memo.	By 4/16/09

Corrective actions to be monitored to ensure the deficiency will not recur: Results of the clinical record audit will be compiled to identify trends and the need for further education.	Beginning May 2009 and each quarter thereafter
A Plan of Correction and education plan will be developed and initiated for audit results less than 85%.	
Results of the Utilization Review Committee record audits and action plans will be presented to the Quality Assurance/Performance Improvement Committee and Professional Advisory Committee quarterly for review and recommendation.	
Recommendations from the Professional Advisory Committee will be reviewed and implemented with the clinical managers and staff.	
Responsible Person: Lisa Greisler, Director of Patient Services	

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G236	484.48 CLNICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

RESPONSE:	CORRECTIVE ACTIONS ACCOMPLISHED FOR PATIENTS FOUND TO BE AFFECTED BY THIS DEFICIENCY	COMPLETION DATE
	The clinical managers will review the deficiencies with the involved clinicians.	By 3/31/09
	Patient A, B, C Discharge summaries and assessment will be completed	3/31/09
	Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the clinical audit a focus on discharge assessment completion per VNA policy. Any deficient records will be forwarded to the clinical manager for correction.	Beginning April and quarterly for two quarters
	Measures to ensure the deficiency does not recur are: The Director of Patient Services will reinstruct the Clinical managers and careproviders in the following policies and procedures: • VNA policy SVC 244 "Discharge of a Patient". An OASIS discharge assessment and discharge documentation must be completed in accordance with agency policy and procedures.	By 4/16/09
	Corrective actions to be monitored to ensure the deficiency will not recur: Results of the clinical record audit will be compiled to identify trends and the need for further education.	Beginning May and quarterly thereafter
	A Plan of Correction and education plan will be developed and initiated for audit results less than 85%.	
	Results of the Utilization Review Committee record audits and action plans will be presented to the Quality Assurance/Performance Improvement Committee and	

Professional Advisory Committee quarterly for review and recommendation.

Recommendations from the Professional Advisory Committee will be reviewed and implemented with the clinical managers and staff.

RESPONSIBLE PERSON: Lisa Greisler, Director of Patient Services

TAG	SUMMARY STATEMENT OF DEFICIENCIES
J508	763.5(a)(1-2) PATIENT REFERRAL AND ADMISSION 763.5 Patient Referral and Admission (a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless: (1) The patient's authorized practitioner orders otherwise; or (2) There is written documentation that the patient or family refuses such a visit.

RESPONSE	Corrective Actions Accomplished For Patients Found to be Affected by This Deficiency: The Director of Patient Services will review the deficiencies with the clinicians involved. The clinical records cannot be corrected.	By 3/31/09
	Other patients having the potential to be affected by this deficiency will be identified by: The Utilization Review Committee will include in the monthly clinical record review process, a focus on start of care documentation. Clinical records found to be deficient will be directed to the appropriate clinical manager for correction or counseling of staff if necessary.	Beginning April and quarterly, thereafter
	Measures to ensure the deficiency does not recur are: All clinical staff will be re-educated on VNA policy SVC, 205 "Initial Assessment/Reassessment". This policy states that the initial assessment must be made within 24 hours of receipt of and acceptance of a community referral or on the physician ordered start of care date unless the patient or family refuses the visit. This refusal must be documented in the clinical record. The Patient Care Coordinators and clinical staff will be instructed on the appropriate documentation of patient contact regarding the initial visit.	By 4/16/09
	Corrective actions to be monitored to ensure the deficiency will not recur: Results of the clinical record audit will be compiled to identify trends and the need for further education.	Begin May and quarterly, thereafter
	A Plan of Correction and education plan will be developed and initiated for audit results less than 85%.	
	Results of the Utilization Review Committee record audits and action plans will be presented to the Quality Assurance/Performance Improvement Committee and Professional Advisory Committee quarterly for review and recommendation.	
	Recommendations from the Professional Advisory Committee will be reviewed and implemented with the clinical managers and staff.	
	RESPONSIBLE PERSON: Lisa Greisler, Director of Patient Services.	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

584 Delaware Avenue Buffalo, New York 14202

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

December 18, 2008

Ms. Joyce Markiewicz
McAuley Seton Home Care Corporation
14 Appletree Business Park
Cheektowaga, NY 14227

Re: Complaint **#NY00065610**

Dear Ms. Markiewicz:

Please be advised that this office has received the investigative report relating to Western Regional Office of the New York State Department of Health complaint **# NY00065610**.

The report was found to be acceptable, and it is expected that you will implement the resolutions as stated. The Department reserves the right to reopen the investigation of this matter at some future time should additional evidence be provided or an appeal filed.

If you have any further questions regarding this matter you may call me at (716) 847-4320. Thank you for your cooperation.

Sincerely,

Margaret M. Jordan
Home Care Director
Western Regional Office/Buffalo

MMJ/tmc